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ABSTRACT

This book of school health guidelines provides a model for the development of a modern school health program or the enrichment of a program already existing. It addresses the areas of school health services, health education, and a healthful school environment. It contains information, tools and techniques for the development of a program that prepares students to maintain and improve their own health and to protect the health of others. (Author)

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COLORADO SCHOOL HEALTH GUIDELINES

Colorado Dept.
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COLORADO SCHOOL HEALTH GUIDELINES

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Produced jointly by

Colorado Department of Education
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Denver, Colorado
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- INTRODUCTION -

Educators, parents, and health professionals have long been aware that good health is basic to sound education. Good health allows the student to take full advantage of the educational activities offered in the school setting; to the adult, good health affords the opportunity to apply the knowledge and skills gained in his/her educational experience. Conversely, it is recognized that education is basic to an individual's ability to maintain his/her health. A population that is knowledgeable about health and the health care system will utilize health services more rationally and will take measures to promote health and well-being.

The primary responsibility for the health of the student rests with the parents. However, a vital portion of the student's life is spent in the school setting. Therefore, it is natural and beneficial that the school and the parents work cooperatively to provide for the health needs of the student through an effective school health program.

The Colorado School Health Guidelines provides a model for the development of a modern school health program or the enrichment of a program already existing in the district. It addresses the areas of (a) school health services, (b) health education, and (c) a healthful school environment. It contains information, tools and techniques for the development of a program that prepares students to maintain and improve their own health, and to protect the health of others.

The guidelines have been written with the cooperation of health and education specialists in urban and rural Colorado. They are based on accepted professional standards and a review of current literature in the field.

These guidelines are intended as a model. Local customs, the presence of professional personnel, and the availability of resources will influence the way this guide can be adapted for local use. We urge your careful review and consideration of these guidelines in establishing or enhancing a school health program to benefit the children and youth of Colorado.

Calvin M. Frazier	Anthony Robbins, M.D., M.P.A.
Commissioner of Education	Executive Director
Colorado Department of Education	Colorado Department of Health

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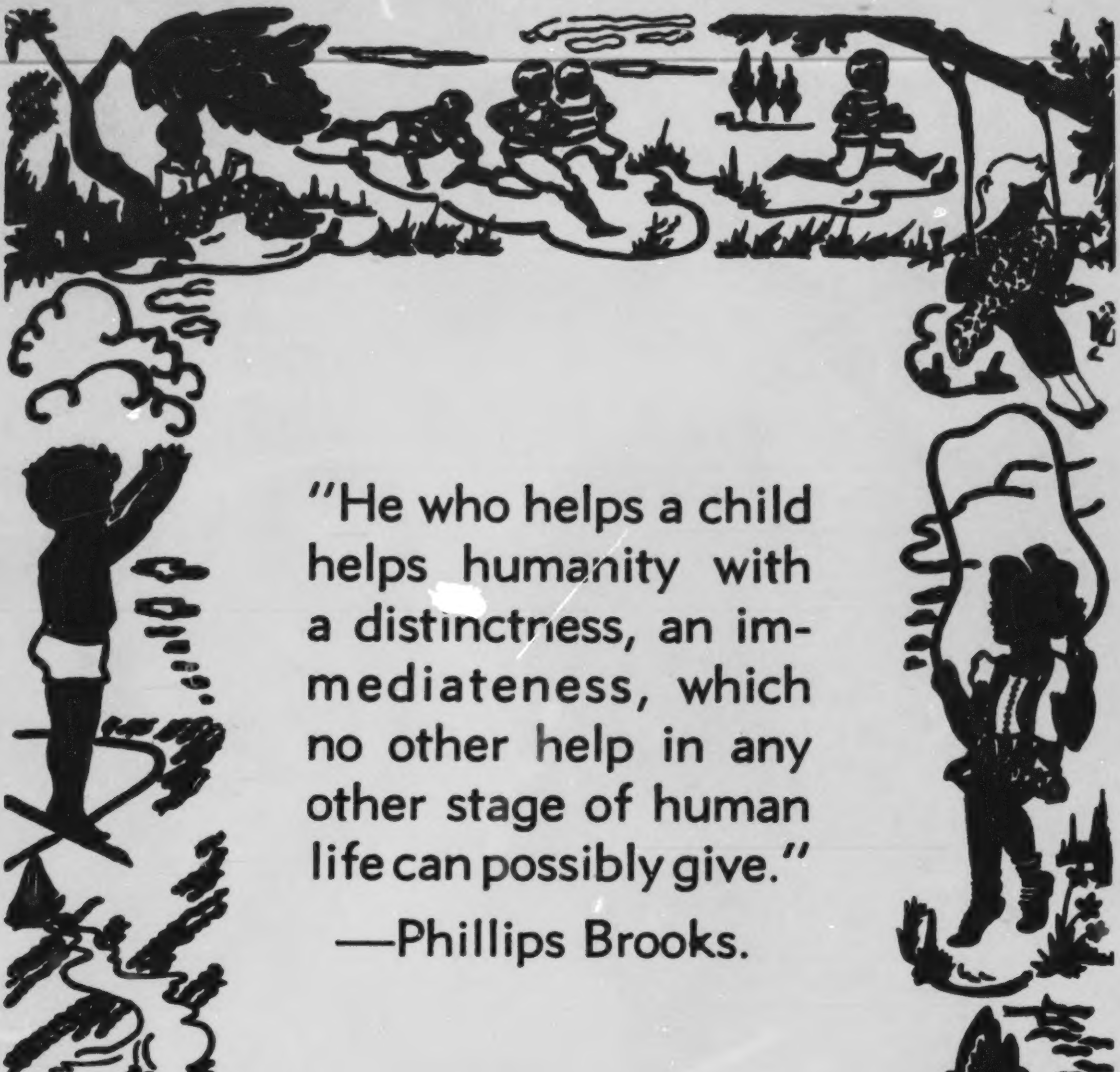

"He who helps a child helps humanity with a distinctness, an immediateness, which no other help in any other stage of human life can possibly give."

—Phillips Brooks.

Taken from CONSERVING THE HEALTH OF COLORADO'S CHILDREN: A HANDBOOK FOR TEACHERS, produced jointly by the Department of Education and the Division of Public Health, 1944.

COLORADO SCHOOL HEALTH GUIDELINES

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SCHOOL HEALTH SERVICES

CHAPTER I

CURRENT PHILOSOPHY, PURPOSE, AND BACKGROUND

Philosophy and Purpose

The primary objective of the school health service, as provided by the professional school nurse, is to strengthen the educational process of children and youth by assisting them to improve or adapt to their health status. It has been indicated that the quality and quantity of learning of each student is in direct proportion to his physical, mental, emotional and social levels of health.

The Colorado Advisory Committee on School Health, first organized by the Colorado Department of Education in 1948, developed the following statement on the philosophy of school health services in 1967. It is still appropriate and timely.

> *Good health is basic to sound education and productive living. A high level of physical, mental, emotional, and social well-being is necessary to enable a child to function at his full capacity in the classroom so that he may develop into a healthy, productive adult. Good health means more than the negative concept--the absence of disease. It is defined by the World Health Organization as a "...state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."*
>
> *School health is an inevitable segment of community health. In addition, it has its own primary concern, that of maintaining and improving the health of children and youth to assure their optimum functioning within educational programs. It has been called "industrial health" for the school-age population. This analogy is a helpful one for the screening and preventive services and for care of illnesses and accidents, although "school health" in this country does not parallel "industrial health" in the diagnosis and treatment services often provided to adults at their work.*
>
> *A school health service program is never the work of one, or even a few persons, but the combined effort of many. It should utilize the work with all community health resources as private medicine and dentistry, public health clinics, voluntary agencies, and civic groups.*[1]

The school administrators, school nurses, teachers, parents, and advisory persons in each school district should develop their philosophy and purpose for their school health services taking into consideration background information, local community needs and State law requirements. The program should be developed for the benefit of all the students within their district.

Historical Background

The historical background of school health service programs was well summarized by this same group - the Colorado Advisory Committee on School Health. It stated:

> *School health service programs have long and widespread roots. In brief summary they go back to the early 1800's when William Alcott wrote an essay in 1832 on safe construction of schools, suggested the attendance of a physician to deal with some problems among pupils, and prepared the first health book for children. Horace Mann spoke of "school hygiene" in his first annual report as secretary of the Massachusetts Board of Education in 1838. The first public school medical officer was appointed in 1892 in New York City and the first regular system of medical inspection of children is recorded to have started in Boston in 1894, Chicago in 1895 and Philadelphia in 1898. In 1899, public school personnel of Connecticut were required to test the vision of pupils. In 1902, the first school nurse was employed by the New York City Schools. Other cities quickly employed school nurses--among them Boston, Philadelphia, Los Angeles, and Denver. In 1903, Reading, Pennsylvania, appointed the first school dentist. In 1906, Massachusetts was the first state to make medical inspections of pupils compulsory. Perhaps Philadelphia was the first city to offer a high school course in hygiene, physiology, and the first aid for such a course was given there in 1845. Dental care was financed in 1910 in the Cincinnati and New York City schools and the first school dental hygienists were employed in 1914 in Bridgeport, Connecticut. By 1910, 337 cities in the United States were requiring medical inspections and school systems were employing 1,194 doctors, 371 nurses and 48 dentists.*
>
> *Great changes in public health education and community health services occurred simultaneously in the latter part of the last century. Epidemics were controlled, sanitation standards established, welfare and medical aid planned for the needy, and education extended to all.*
>
> *And with these changes, health programs in schools metamorphosed too. Four fairly disinct phases have occurred in the past seven or eight decades. The first emphasis was control of epidemic diseases such as typhoid, tuberculosis, smallpox, diphtheria, and whooping cough among the young. Next came the concern for sanitation and safety of school buildings and grounds so medical personnel and nurses moved from being "disease control officers" to being "sanitary inspectors." Communities become conscious that if children were compelled to attend school, then schools must be made safe for them.*

> *The third general era of school health has been a focus on physical defects, stimulated considerably by World Wars I and II when the findings of many physical and mental deficiencies among draftees surprised the nation.*
>
> *Currently we have evolved to the fourth emphasis--that of applying medical, nursing, and other health skills to the educational needs of pupils. The previous three emphases are still valid but new challenges are now faced by school health. An awareness of "learning problems," "dropouts," and "exceptional children" has emerged as most communities have accomplished control of the epidemic diseases, met basic sanitation and safety regulations and have some plans for detection and care of severe physical defects. Federal funding is a transfusion to these newer plans and to school districts. Thus health skills are needed in educational programs at this time as much as in earlier decades. With this, school health is now in its fourth emphasis--that of helping every child to function at his optimum in the learning situations of the school and for his future years. Presently physicians, nurses, audiologists, psychiatrists, dentists, dental hygienists, and various technicians and aides comprise the health team at work in schools. They may be employed by boards of education, boards of health, other community groups, or a combination of these. Their concern should be the most efficient program to meet those pupil health needs which are of significant learning.*[2]

Within the past few years, Colorado has passed the laws relating to school health in the areas of "Immunization Certificates Prior to School Enrollment" and "Handicapped Children's Educational Act." These two laws have greatly influenced school health services. In many areas of Colorado it helped to liberate the school nurse from the role of a "Band-Aid Queen," when she tended to put on Band-Aids and send sick children home.

---

1. School Health Services Handbook for Administrators and Health Personnel, Colorado Advisory Committee on School Health, 1967, p. 1.
2. School Health Services Handbook for Administrators and Health Personnel, Colorado Advisory Committee on School Health, 1967, p. 1.

CHAPTER II

PLANNING AND ADMINISTRATION

Administrative Patterns in Colorado

There are three major administrative patterns used in Colorado for providing services in the school health program. In one, the local board of education operates its own health services and the school nurse is employed by the school district. In pattern two, the local health department or county nursing service operates the health services within the school system and the nurse is employed full or part time by the health department, or county nursing service. The local board of education may or may not pay for these services, depending on local agreement between the two agencies. And thirdly, coordinated authority for administering and/or funding the school health program may come from the local board of education and the local health department or county nursing service.

Responsibilities

It has already been pointed out that team work is essential to develop a good health service program. However, certain individuals are in the position of making the final decision and giving direction to the program.

The ultimate responsibility for the school health program is that of the local boards of education, the elected representatives of the people of the school district. However, in practice the school board usually delegates this responsibility to its superintendent.

In the School Health Services Handbook for Administrators and Health Personnel, prepared under the supervision of the Colorado Advisory Committee on School Health, these responsibilities were stated and remain very appropriate.

> *Responsibilities of the Superintendent Authority*
>
> *The superintendent has the crucial role of planning and developing health services within his school district. His function is to provide guidance and encouragement for the school board as they develop and establish policies for school health services. In turn, the school board delegates to the superintendent the responsibility and authority for carrying out these policies in all the schools in the district.*
>
> *Developing Awareness and Understanding*
>
> *The implementation of policies must be conducted on a district-wide basis. It cannot be left to a hit-or-miss procedure. The superintendent is responsible for creating the proper climate and providing ample opportunity for development of the school health services program. He must provide leadership for principals, teachers, coordinators and other related staff to implement*

a health services program that is coordinated well with the instructional program and that relates solely to health education and the school environment.

There are several approaches, involving various personnel and agencies, that a superintendent may follow in fulfilling his responsibility. Above all he must see to it that the school health service program is based upon the school related needs of children and youth in his district.

Oftentimes the establishment of a school health council or committee is valuable if a similar representative group does not already exist among the PTA, public health, or other community leaders. In general, the functions of such a council are threefold:

- *a. to identify significant school related health problems and needs*
- *b. to study and analyze these problems, and*
- *c. to make recommendations to the administration for eliminating or reducing the problems and needs.*

In planning the health service program, the health council can make full and effective use of the various abilities and backgrounds of the people who serve on the council. While individual and agency resources will vary with the community, it is desirable to include the following types of personnel on the school health council or health advisory committee.

1) *Principals and/or other administrators*
2) *School health coordinator or supervisor*
3) *Teachers*
4) *Nurses (representing the schools and/or the local or state health department)*
5) *Private practitioners in medicine and dentistry*
6) *Representatives from the local health department*
7) *Representatives from voluntary health agencies*
8) *Parents, and*
9) *Student leaders*

Working Relationship

The superintendent also has the responsibility for establishing good working relationships with those community organizations and agencies which may cooperate with the schools in planning and conducting an effective health service program. Policies defining the role of these agencies should be carefully delineated and set down in the Board of Education Policy Manual.

Many schools have health specialists on their staffs. These specialists--nurses, dental hygienists, psychologists, and others--should be encouraged to work closely with personnel in other public agencies in the community or at the state level. However, many schools do not have specialized personnel. In such schools, a policy should be developed concerning working relationships with public agencies. The policies should be definitive enough so that principals and teachers know exactly what they may or may not do. Such policy must also protect school personnel from arbitrary and unjust legal involvement.

Responsibilities of the Principal

After the general plan of a school health program is established and approved by the top administrative staff and the Board of Education, the most important person in activating it is the principal.

As an orchestra needs a conductor, so the intra-school team and/or the school-community team needs a leader close at hand. The principal holds this position by rule, regulation, and/or practice and has direct responsibility and authority to "call the TUNE" and to harmonize the efforts of his staff members.

Essential to success is his skill in developing working relationships among all those involved in the program.

General Ingredients for Effective Relationships

Whenever more than one adult is working with a child, interrelationships occur. Those within a school should be recognized, appreciated, and well utilized for the benefit of the pupil. Effective relationships are based on:

a. mutual respect
b. ready ways of sharing information and data
c. acceptance of common objectives among the teachers, administrators, health and other personnel.

The larger the number of persons involveed, the more complicated, yet challenging, are their relationships. Good organization and efficiency are enhanced if everyone involved thinks first and foremost of the welfare and desirable development of the pupils.

The Principal's Leadership is Essential

The principal must adapt and coordinate the available health resources according to the needs of the school. The resources vary widely in our state according to whether or not the health trained auxiliary personnel (doctors, dentists, nurses, dental hygienists, audiometrists, health educators, and psychiatrist)

> *are in the community, in private practice; in the official public health agency; in voluntary health organizations; or employed by the schools themselves. Likewise, the methods of work and the amount of service given to schools vary greatly among counties in Colorado. But trained health persons from all these sources can contribute effectively to school health within the efficient and local pattern of organization.*
>
> *The principal is the key person in all aspects of the school program. His understanding and interest largely determines its degree of success or failure.*[3]

Responsibility of the School Nurse Supervisor or Coordinator

The school nurse, as part of the professional team concerned with providing an adequate and effective school health service, has a unique contribution to make from her nursing knowledge and skills. School nurses should be supervised by someone knowledgeable in the health service field. This supervisor or coordinator should work with the school administration in planning a school health program considering those priorities which have been established by education in addition to those established by nursing.

In school districts employing several school nurses, there should be a nursing supervisor or coordinator. This person can give direction to the program and the other school nurses, as well as coordinate the activities to give a unified approach within a school. Also, such a staff leader should interface the school program with those in the community. In rural Colorado where there is only one school nurse in the district, consultation should be available to the school nurse from a local medical advisor or local health department and/or the Colorado Department of Health.

Colorado School Laws

There are also several Colorado laws relating to school health services which need to be taken into consideration in the planning and administration of a school health services program. These laws include:

a. Written policies required in schools. 22-32-109(^{w})

b. Board of Education - specific powers to report student defects. 22-32-110(bb).

c. Physical examinations on school children. 22-1-116

d. Minors - consent for medical care and treatment for addiction to or use of drugs. 13-22-102

e. Certain minors competent - Consent for medical and dental care. 13-22-103

f. Physical examination and parental consent for athletes.

g. Immunization certificates prior to school enrollment. 25-4-901

h. Board of Education - purchase of accident insurance for pupils. 22-32-110(v)

i. Handicapped Children's Educational Act. 22-20-101

j. Birth control services rendered to minors by physicians. 13-22-105

k. Policy and authority regarding contraceptive information, supplies, etc. 25-6-102

l. Reporting child abuse. 19-10-101

m. Public records - Inspection, copying, and photographing. 24-72-201

n. New school finance law. 22-50-101

o. Venereal disease services rendered to minors by physicians. 25-4-402

These are only some of the Colorado laws pertaining to school health. The Colorado Department of Education compiled and published a book titled Colorado School Laws 1976. This publication is sent to superintendents and to other interested persons on request, and they list and explain the laws. (See Exhibit I for details of these laws.)

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3. School Health Services Handbook for Administrators and Health Personnel, Colorado Advisory Committee on School Health, 1967, p. 7-9.

EXHIBIT I

Some Colorado Laws Relating to School Health

a. 22-32-109(w). Written policies required in schools. Requires that school districts shall have written policies, rules, and regulations relating to study, discipline, conduct, safety, and welfare of pupils enrolled in the district. Requires procedures in writing relating to the expulsion or denial of admission to a pupil. The procedures adopted shall afford due process of law to pupils, parents, and school personnel.

b. 22-32-110(bb). Board of Education - specific powers to report student defects. To require every teacher in the public schools to report the mental, moral, and physical defectiveness of any child under his supervision as soon as such defectiveness is apparent to the principal or where there is no principal, to the district or county superintendent. Such principal or superintendent shall promptly notify the parents or guardian of each child found to be defective, of the child's defectiveness, and shall recommend to such parent or guardian that such child be thoroughly examined as soon as possible by a person licensed to care for or treat such defect. If the parents or guardian of such child shall fail, neglect, or refuse to have such examination made and treatment begun within a reasonable time after such notice has been given, the said principal or superintendent shall notify the board of education of such fact. Whenever it shall be made to appear to the said principal or superintendent that such parent or guardian does not have the necessary funds to pay the expenses of such examination and treatment, the said principal or superintendent shall report such fact to the appropriate public welfare agency.

c. 22-1-116. Physical examination on school children. The state commissioner of education shall prepare or cause to be prepared suitable test cards, blanks, record books, and other needful appliances and supplies to be used in testing the sight, hearing and breathing of pupils in the public schools, and the necessary instructions for their use; and shall furnish the same free of expense to every public school in the state. The teacher or principal in every public school, or where there is no principal, the county superintendent, during the first month of each school year, shall test the sight, hearing and breathing of all pupils under his charge, such examination to be made by observation, without using drugs or instruments and without coming in contact with said child; and to keep a record of such examinations according to the instructions furnished and make a written report of such examinations to the state commissioner of education as he may require.*

d. 13-22-102. Minors - consent for medical care and treatment for addiction to or use of drugs. Notwithstanding any other provision of law, any physician licensed to practice in this state, upon consultation by a minor as a patient, with the consent of such minor patient, examine, prescribe for, and treat such minor patient for addiction to or use of drugs, all without the consent of or notification to the parent, parents, or legal guardian of such minor patient, or to any other person having custody of such minor patient. In any such case the physician or any person acting pursuant to his direction shall incur no civil or criminal liability by reason of having made such examination or prescription or having rendered such treatment, but such immunity shall not apply to any negligent acts or omissions by the physician or any person acting pursuant to his direction.

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*This is an old law, however, it is still on the books. Breathing screening is no longer done in Colorado schools.

e. 13-22-103. Certain minors competent-consent for medical and dental care. (1) Except as otherwise provided in sections 18-6-101 and 25-4-402 C.R.S. 1973, a minor 18 years of age or older, or a minor 15 years of age or older who is living separate and apart from his or her parent, parents, or legal guardian, with or without the consent of his or her parent, parents or guardians, and is managing his or her own financial affairs, regardless of the source of his or her income, or any minor who has contracted a lawful marriage, may give consent to the furnishing of hospital, medical, dental, and surgical care to himself or herself. Such consent shall not be subject to disaffirmance because of minority, and when such consent is given, said minors shall have the same rights, powers, and obligations as if they had obtained majority. (2) The consent of the parent, parents, or legal guardian of a minor described in subsection (1) this section shall not be necessary in order to authorize hospital, medical, dental, or surgical care, and no hospital, physician, surgeon, dentist, or agent or employee thereof, who, in good faith relies on such a minor's consent, shall be liable for civil damages for failure to secure the consent of such a minor's parent, parents, or legal guardian, prior to rendering such care. The parent, parents, or legal guardian of a minor described in subsection (1) of this section shall not be liable to pay the charges for the care provided said minor on said minor's consent, unless said parent, parents, or legal guardian agree to be so liable. (3) Any parents, including a parent who is a minor, may request and consent to the furnishing of hospital, medical, dental, and surgical care to his or her child or ward. The consent of a minor parent shall not be subject to disaffirmance because of minority, and when such consent is given, said minor parent shall have the same rights, powers, and obligations as if he or she were of legal age.

f. Physical Examination and Parental Consent for Athletes - from the Handbook of the Colorado High School Activities Association.

Section 9: No pupil shall represent his school in inter-school athletics until there is on file with the superintendent or principal a statement signed by his parents or legal guardian and a practicing physician certifying that he has passed an adequate physical examination within the past year; that in the opinion of the examining physician he is physically fit to participate in high school athletics; and that he has the consent of his parents or legal guardian to participate.

g. 25-4-901 thru 25-4-907. Immunization certificates prior to school entry. As a prerequisite for entry into schools the immunization of children against communicable diseases, as specified by the Department of Health, will be required, starting after July 1, 1974.

25-4-901. Definition. - As used in this article, unless the context otherwise requires, "school" means public, private, or parochial nursery school, day care center, child care facility, head start program, or elementary school.

25-4-902. Immunization prior to entering school. - Except as provided in section 66-40-3 and 66-40-7, no child shall be admitted to any school for the first time in the state of Colorado unless such child can present to the appropriate official of the school or facility certification from a licensed physician or authorized representative of the department of health or local health department stating that such child has received immunizations against communicable diseases as specified by the department of health or a written authorization signed by one parent or guardian requesting that local health officials administer the immunizations.

25-4-903. Exemptions from immunization. - (1) A child may enter school provisionally upon submitting written proof from a licensed physician or local health department stating that he is in the process of receiving the required immunizations. Further certification showing that the required immunizations have been completed must be submitted to the appropriate official of the school or facility no later than four months after the child first attended the school or facility.

(2) A child may be exempted from receiving the required immunizations:

(a) Upon submitting certification from a licensed physician that the physical condition of the child is such that immunizations would endanger his life or health.

(b) Upon submitting a statement signed by one parent or guardian that the child is an adherent to a religious belief whose teachings are opposed to immunizations.

25-4-904. When exemptions from immunization are not recognized. - If at any time there is, in the opinion of the state or local health department official, danger of an epidemic from any of the communicable diseases for which immunization is required under these regulations, no exemption from immunization against such disease shall be recognized. Quarantine is a legal alternative to immunizations.

25-4-905. Immunization rules and regulations. - (1) Rules and regulations for administering the law shall be established by the state board of health. Immunizations required, and the manner and frequency of their administration, as prescribed by the department of health, shall conform to recognized standard medical practices. The department of health shall administer and enforce the immunization requirements.

(2) The list of diseases and minimum requirements for protection may be revised whenever the department of health deems it necessary for the protection of the public health.

25-4-906. Immunization of indigent children. - The local health department, a public health or school nurse (under the supervision of a licensed physician), or the department of health in the absence of a local health department or public health nurse shall, at public expense to the extent that funds are available, provide the immunizations required by this article to each pupil whose parents or guardians cannot afford to have the pupil immunized and who have not been exempted. The department of health shall provide all vaccines necessary to comply with this section as far as public funds will permit. Nothing in this section shall preclude the department of health from distributing vaccines to physicians or others as required by law or the regulations of the department.

25-4-907. Certification and certification forms. - (1) The department of health shall provide the forms for certification to the schools, facilities, private physicians, and local health departments. Any immunization record signed by a licensed physician may be accepted by the school official as certification if the information is transferred to the official certification form and verified by the school official.

(2) On or before November 15 of each year, a school official shall deliver the certifications to the department of health. School authorities shall not deny the right of a child to enter school, but are required to provide the department of health with a list of enrollees not complying with the law by November 15.

h. 22-32-110(v). Board of Education - Purchase of accident insurance for pupils. Authorizes school districts to purchase accident insurance covering the medical expenses of any pupil who may be injured while being furnished transportation by the school district.

i. 22-20-101 thru 22-20-114. "Handicapped Children's Educational Act" - amended to establish procedures for identifying which children shall be entitled to state categorical support assistance. Establishes the nature of programs which will qualify for state assistance, requires that a director of special education programs shall be designated, and spells out procedures for the administration of the Act. Retains, in the law, the requirement that all children eligible for participation in special education programs shall have such programs provided.

j. 13-22-105. Birth control services rendered to minors by physicians. Except as otherwise provided in part 1 of article 6 of title 18, C.R.S. 1973, birth control procedures, supplies, and information may be furnished by physicians licensed under article 36 of title 12, C.R.S. 1973, to any minor who is pregnant or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher, learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

k. 25-6-102. Policy and authority regarding contraceptive information, supplies, etc. - (1) All medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship, or motive.

(6) Notwithstanding any other provision of this act, no unmarried person under 18 years of age may consent to permanent sterilization procedures without the consent of parent or guardian.

(8) Dissemination of medically acceptable contraceptive information by duly authorized persons at schools, in state and county health and welfare departments, in medical facilities at institutions of higher learning, and at other agencies and instrumentalities of this state is consistent with public policy.

l. 19-10-101. Reporting of child abuse and neglect. When any physician, medical institution, nurse, school employee, social worker, or any other person has good reason to believe that a child has been subjected to abuse, or observes the child being subjected to conditions or circumstances which reasonably would result in abuse, he shall report such incident or cause a report to be made to the proper local social service agency or law enforcement agency. Such report may be made orally by telephone, and shall be followed by a written report if requested by the law enforcement agency, and, to the extent available, shall contain the address and age of the child, the address of the person or persons having custody of the child, the nature and extent of the child abuse, or the conditions and circumstances which would reasonably result in such abuse, any evidence of previous abuse including the nature and extent, and any other information which in the opinion of the person may be helpful in establishing the cause of such abuse and the identity of the perpetrator or perpetrators.

"Abuse" or "child abuse or neglect" means any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive, or death, and such condition or death is not justifiably explained, or where the history given concerning such condition or death is at variance with the degree or type of such condition or death, or circumstances indicate that such condition or death may not be the product of an accidental occurrence.

m. 24-72-201 thru 24-72-206. Public Records - inspection, copying and photographing. This "open records" law covers school records, both on pupils and adults and allows parents, guardians and "persons at interest" to request copies of the records at reasonable times and

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in compliance with rules and regulations set by the custodian of the records - i.e. the superintendent of schools for the eductional system.

Sections of the law particularly applicable to the schools are:

24-72-204(3)(VI)(b). Nothing in this subsection (3) shall prohibit the custodian of records from transmitting data concerning the scholastic achievement of any student to any prospective employer of such student, nor shall anything in this subsection (3) prohibit the custodian of records from making available for inspection, from making copies, printouts, or photographs, or from transmitting data concerning the scholastic achievement, or medical, psychological, or sociological information of any student to any law enforcement agency of this state, of any other state, or of the United States where such student is under investigation by such agency and the agency shows that such data is necessary for the investigation.

24-72-204(3)(VI)(c). Nothing in this subsection (3) shall prohibit the custodian of the records of a school, including any institution of higher education, or a school district from transmitting data concerning standardized test, scholastic achievement, or medical, psychological, or sociological information of any student to the custodian of such records in any other such school or school district to which such student moves, transfers, or makes application for transfer, and the written permission of such student or his parent or guardian shall not be required therefor. Nor shall any state educational institution be prohibited from transmitting data concerning standardized tests or scholastic achievement of any student to the custodian of such records in the school including any state educational institution, or school district in which such student was previously enrolled, and the written permission of such student or his parent or guardian shall not be required therefor.

n. 22-50-101. New school finance law - allowing state funds to be utilized to supplement local property tax revenues. The plan guarantees that each school district shall have revenue amounting to not less than $25 per pupil per mill in 1974, $27 in 1975, and $29 in 1976. Minimum state equalization support is eatablished at $8 per pupil per mill for 1974, $9 in 1975, and $10 in 1976. The existing concept of budget limitation has been repealed. Instead, a limitation on the amount of revenue a district may receive from property tax sources plus state equalization support is established. A state budget review board is established with authorization to waive the revenue limitation for a school district, if necessary For the budget year 1975, and thereafter, school district revenue limits may be increased if approved by a vote of the people. For the state as a whole, school revenues from these sources, for 1974, will be increased by approximately $61.2 million. 1974 property tax requirements, as compared with 1973, will be reduced by approximately $72.6 million. (This stabilizes and increases state funding for public schools and thereby could allow development and/or extension of their health programs.)

o. 25-4-402. Venereal disease services rendered to minors by physicians.
(4) Any physician, upon consultation by a minor as a patient, with the consent of such minor patient, may make a diagnostic examination for venereal disease, and may prescribe for and treat such minor patient for venereal disease, all without the consent of or notification to the parent, parents, or guardian of such minor patient, or to any other person having custody of such minor patient. In any such case the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions.

p. 25-24-101. Control of Smoking - Legislative Declaration. (S.B. 137 became law 7/1/77) The general assembly hereby declares that the smoking of tobacco or any other plant or weed under certain conditions is a matter of public concern and that in order to protect the public health, safety, and welfare it is necessary to control such smoking in certain public places.

25-14-102(2) Definitions
(2) "Public place" means any enclosed, indoor area used by the general public or serving as a place of work including, but not limited to, restaurants, retail stores, other commercial establishments, governmental offices, waiting rooms of health care professionals, public conveyances, educational facilities, hospitals, nursing homes, auditoriums, arenas, assembly and meeting rooms, and restrooms, but the term does not include enclosed offices occupied exclusively by smokers, even though such offices may be visited by nonsmokers.

25-14-103. Smoking prohibited in certain public places.
(1) Except as otherwise provided in this subsection (1), smoking is prohibited in the following public places:

(f) Classrooms, corridors, and rest rooms in schools. All other areas in schools shall be deemed nonsmoking areas except those specifically designated for smoking by the appropriate authority having control of the physical facilities of the school.

(3) The owner, manager, or any person in charge of a public place specified in subsection (1) of this section shall control smoking throughout such public place by posting signs which clearly designate nonsmoking and, where provided, smoking areas. Such signs shall be explicit and conspicuous, but the wording, size, color, design, and place of posting shall be at the discretion of the owner, manager, or person in charge.

CHAPTER III

RECOMMENDED POLICIES

There is a need for basic policies in the school health service program to give direction to efforts designed to protect and improve the health of the students. These should include policies for:

Emergency care for injury and sudden illness
First aid supplies
Medications given at school
Child abuse reporting
Compliance with the immunizations law
Health component fo the Handicapped Children's Educational Act
Overall school health policies for school nurse services

Formulating these policies is the responsibility of the school administrators and school boards, but there should be input from the school health personnel, and knowledgeable groups, such as the local medical society and the local, county or state health department.

Emergency Care for Injury and Sudden Illness

The school is responsible for the emergency handling of accidents and sudden illness occurring at school, on school property, or during school sponsored activities. The school is not responsible for subsequent treatment or medical expense incurred after the administration of first aid.

The Colorado Department of Education printed a flip-chart in 1974, titled "Emergency Care of Sickness and Accidents Occurring at School." This flip-chart should be readily available for use in every school. Furthermore, the school is responsible for providing adequate facilities, supplies, and personnel trained in American Red Cross First aid or an equivalent. (See Exhibit II for list of recommended supplies for emergency care.)

Each school district should have a comprehensive emergency care policy written and approved by the school administration, school nurse, school staff, parents, and local medical advisory board or the local medical society.

A recommended procedure for acute illness or injury would be:

1. Give immediate and temporary first aid care to sick or injured students.

2. Notify the child's parents or guardian. In all cases where it is possible to do so, wait for instructions from the parents or guardians before proceeding further. The school's responsibility is limited to first aid. Its right to give treatment goes no further than such treatment as will protect the life and comfort of the individual until additional treatment is secured.

3. The school district should have a "Child Emergency Card" delegating the person to contact and the family physician, in case the parent can not be reached.

4. Get the pupil home or to a physician or hospital safely and as promptly as may be arranged. School personnel, including nurses, do not transport a seriously injured child to the doctor's office or hospital. If the parent can not provide transportation, an ambulance should be called.

5. No injured or ill child should be allowed to walk home or be unaccompanied by an adult if he/she has an obvious injury. It should be ascertained beforehand that a responsible person is at home to receive the child.

6. After an accident of any sort, to insure accurate information for future use, a record should be made immediately. (See Exhibit III for a sample form.)

7. The school reserves the right to act as is necessary in the opinion of school personnel in a life or death situation.

Medications Given at School

Medications are rarely necessary for pupils during the school day. They are justified in some chronic health conditions or short-term acute health conditions. However, the supplies of aspirin, cough and cold medications, digestants, and the like which pupils frequently bring to school should occur only when prescribed by a physician.

No medication should be administered by any school personnel including the nurse, except on the written orders of a physician. These medications should be safeguarded at school to avoid any risk they might be ingested by the wrong child.

A recommended procedure for administering justified medications by school personnel would be:

1. If under exceptional circumstances a child is required to take oral medication during school hours and the parent can not be at school to administer medication, only the school nurse or the principal's designee will administer the medication in compliance with the school's regulations.

2. Written orders from the student's physician should be on file [illegible] school stating:

   a. Child's name
   b. Name of drug
   c. Dosage
   d. Purpose of the medication
   e. Time of day medication is to be given
   f. Anticipated number of days it needs to be given in school
   g. Possible side effects.

3. The medication must be brought to school in a container appropriately labeled by the pharmacy or physician.

4. A specific cabinet should be provided in the school for the storage of medications. It should be provided with a lock.

5. Older and more mature students are capable of taking their own prescription drugs and may bring their daily dose with them, thus relieving school personnel of this responsibility.

6. The school nurse shall organize a practical plan for the administration of medication. The precise time and medication dose should be clearly stated, so that in the absence of the nurse specific directions are available.

7. An individual record shall be kept of such prescription medications administered by school personnel.

(see Exhibit IV for a sample form of "Permission for Medication.")

Reporting Child Abuse and/or Neglect

Cases of child abuse or neglect or "battered" children are often first suspected or detected by school personnel. A Colorado statute (19-10-102 to 115) requires the reporting of these cases to the appropriate county department or local law enforcement agency. It is the intent that, as a result of such reports, protective social services shall be made available in an effort to prevent further abuses and to safeguard and enhance the welfare of such children.

In the new child abuse bill enacted in the 1976 session the "school official or school employee" is listed as one of the persons required to report abuse or neglect. The new bill goes further to state that any person, who is listed to report, who willfully fails to report a case of child abuse or circumstances, or conditions which would reasonably result in child abuse "commits a class 2 petty offense and, upon conviction thereof, shall be punished by a fine not to exceed $200.00 and shall be liable for damages proximately caused thereby." No person who reports a case of suspected child abuse can be sued for making a good-faith report.

The information that should be included in the initial report of suspected abuse is:

1. Name, address, age, sex, race of the child.

2. Name and address of parent, or guardian.

3. Nature and extent of child's injuries.

4. Name and address of the person(s) responsible for the suspected abuse or neglect.

5. Family composition.

6. Source of the report, and name, address, and occupation of person making report.

7. Any action taken by the reporting source.

8. Any other information that the person making the report believes may be helpful.

The Colorado Department of Social Services and local social service offices have a specific form, for reporting this information, called "Child Abuse/Neglect Report." (CWS59). This form is available to schools and does contain the above information.

Each school district should develop procedures to fulfill their obligation to their students in conformity with the Colorado Child Abuse and Protection Act. These procedures should be written and approved by school administration, school health personnel, medical advisory board or the local medical society, parents, and the county department of social services.

A recommended procedure for this would be:

1. When a student has been identified with good reason as having been abused or neglected or "battered," it should be reported to the principal.

2. After consultation with the social worker and/or school nurse, the evidence or circumstances should be well documented and then the principal or his designee should report the case to the appropriate county department or local law enforcement agency.

3. All necessary data should be made available by the school to the appropriate department or agency that will handle the case report of the abuse or "battering."

4. The school personnel should then follow the recommendations of this agency in handling the situation at school. It should be noted that it is very difficult to remove a child from his home unless there is "hard" evidence of abuse or neglect. However, reporting is important because it will bring assistance to this family.

5. Each school should designate someone (probably the nurse or social worker) to inquire of the appropriate agency as to what happened as a result of the report and then add a brief note on the school's report of the abuse case.

COLORADO DEPARTMENT OF HEALTH
PROCEDURES MANUAL
FOR COMPLIANCE WITH IMMUNIZATION LAW

SCHOOL OR FACILITY ROLE

Make certain a Certificate of Immunization is collected for each child entering a Colorado school or facility for the first time. This includes children transferring to your school from out of state, in grades 1-6. A child entering a kindergarten or elementary school from a child care facility must be recertified. In most cases this will require one additional dose each of Polio and DTP vaccines.

A. Make certain parents of every new child who registers have a Certificate of Immunization (see page 307).

B. A valid Certificate of Immunization -- or an "in-process" statement from a physician or health department (testifying that child is "in-process" of receiving his shots) -- should be collected for each child during the first two weeks of attendance.

NOTE

> A Certificate is considered valid if the child has completed all minimum immunization requirements -- if parent indicates religious objection -- if doctor indicates medical contra-indication -- or if parent gives "signed permission" for health authorities to administer required immunizations.

C. Check Certificate of Immunization for completeness when received.

1. You may validate the Certificate from other acceptable documents, i.e., if parent presents dated family health record, military record, International Certificate of Vaccination, a green medical I.D. card, or baby book. As a school or facility official, make your signature of validation only if record presented meets the minimum requirements as listed on the Certificate of Immunization. (See Immunization Validation Guide, page 306).

2. Any shots a child has received -- if proven by acceptable record -- should be entered on Certificate of Immunization, Part III for "signed permission" children. This is to avoid overimmunization by health authorities.

3. Double check the Certificate of Immunization for compliance with minimum requirements and call to the parents' attention any incomplete immunizations.

4. DO NOT ACCEPT INCOMPLETE CERTIFICATES OF IMMUNIZATION. There must be an appropriate signature on one of the lines in Part II (the IMMUNIZATIONS block) or on one of the lines under Part III.

D. After November 1, fill in a List of Noncompliers (see page 308).

   1. Enter the name of each child for whom you have not received a valid certification, including children "in-process."

   2. Keep a duplicate of the List of Noncompliers as a working copy to be updated as Certificates of Immunization are returned from the noncompliers.

E. Urge parents of children on the List of Noncompliers to come into compliance and submit form before March 15.

F. Sort Certificates into fully immunized, medical contraindications, religious objections, and signed permission groups. "In-process" notes can also be set aside separately.

G. Tally the number in each category.

H. Information on certificates may be transferred to each child's record or originals filed separately. When a child leaves a child care facility, the Certificates of Immunization should be given to parents so that it may be updated and submitted when the child enrolls in another child care facility or in school.

I. Retain "signed permission" Certificates separately to plan for necessary immunizations. Contact your Disease Control Representative (see page 313) for assistance.

J. Fill out the Certification Summary (see page 309).

   1. Report even if all children are in compliance with the law. Every school or facility must report on new children every year.

   2. On the Certification Summary, enter the number of children fully immunized, then those with medical contraindications, religious objections, etc. Please list students in one category only, and be sure to fill in the TOTAL at the bottom.

   3. No report is required on children who attend less than 30 days.

K. Send the List of Noncompliers together with the Certification Summary to the Colorado Department of Health by November 15.

   1. The number of noncompliers listed must equal the number of noncompliers indicated on the Certification Summary.

   2. Keep a duplicate of the List of Noncompliers as a working copy. As noncomplying children turn in Certificates of Immunization or withdraw from your facility, indicate on the duplicate working copy the date of compliance or withdrawal.

L. By April 1, send the duplicate copy of the List of Noncompliers to the Colorado Department of Health to report children who have become fully immunized or withdrawn since the November 15 report.

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NOTE

Students entering a school or facility after November 1, are also required to submit a completed Certificate of Immunization, and every effort should be made to bring these children into compliance with the law. However, DO NOT add names to the existing List of Noncompliers.

IMMUNIZATION VALIDATION GUIDE

DTP and Polio: (OPV or TOPV)	Interruption of the routine immunization schedule with a delay between doses -- regardless of interval -- does not interfere with final immunity and does not necessitate starting the series over again. It is the TOTAL NUMBER THAT COUNTS. Salk (killed virus) Polio vaccine is not acceptable for certification.
Measles:	Accept only live virus vaccine given after March 1965 or a reliable history of having had the disease. Mass immunization compaigns were held in Colorado schools and communities in late 1966 and throughout 1967.
Rubella:	Accept only if immunization was given after June 1969 (vaccine was not available before then). History of disease is not acceptable. Mass immunization campaigns were held in schools throughout the state in 1970. A small yellow record card was given to each child who had the shot in these mass programs.

COLORADO DEPARTMENT OF HEALTH - CERTIFICATE OF IMMUNIZATION

PART I: TO BE FILLED IN BY PARENT AND SUBMITTED TO SCHOOL UPON CHILD'S ENTRY. PLEASE PRINT USING A BALLPOINT PEN AND PRESSING FIRMLY.

CHILD'S NAME		SCHOOL OR FACILITY	DISTRICT
CHILD'S BIRTH DATE		ADDRESS	
PARENT'S NAME		CITY	COUNTY
PARENT'S ADDRESS	TELEPHONE	GRADE ENTERING	
CITY	COUNTY	CHILD'S PHYSICIAN	CITY

PART II: IMMUNIZATIONS TO BE COMPLETED BY PHYSICIAN OR PROPER HEALTH OR SCHOOL AUTHORITY.

MINIMUM REQUIREMENTS	VACCINE	ENTER MONTH AND YEAR EACH IMMUNIZATION WAS GIVEN. DOSES			
PRE-ELEMENTARY SCHOOL: 3 DOSES ELEMENTARY SCHOOL: 4 DOSES*	DIPHTHERIA - TETANUS - PERTUSSIS (DTP OR BABY SHOTS)	1 /	2 /	3 /	4 /
- OR - INITIAL SERIES AFTER AGE 6: 2 DOSES	- OR - TETANUS - DIPHTHERIA (TD)	1 /	2 /		
PRE-ELEMENTARY SCHOOL: 3 DOSES ELEMENTARY SCHOOL: 4 DOSES*	ORAL POLIO	1 /	2 /	3 /	4 /
- OR - INITIAL SERIES AFTER AGE 6: 2 DOSES		1 /	2 /		
1 DOSE OR HISTORY OF DISEASE	MEASLES (HARD, RED)	1 /	OR DATE CHILD HAD DISEASE YEAR		
1 DOSE; HISTORY OF DISEASE NOT ACCEPTABLE	RUBELLA (GERMAN MEASLES)	1 /			

TO THE BEST OF MY KNOWLEDGE, THIS CHILD HAS RECEIVED THE ABOVE IMMUNIZATIONS.

SIGNED ______________________ TITLE ______________ DATE ______________
(PHYSICIAN, NURSE OR OTHER HEALTH AUTHORITY)

VALIDATED FROM OTHER ACCEPTABLE DOCUMENTS.

SIGNED ______________________ TITLE ______________ DATE ______________
(SCHOOL, FACILITY OR HEALTH OFFICIAL)

*IF A CHILD IS JUST COMPLETING INITIAL DTP OR POLIO SERIES AT BEGINNING OF SCHOOL - - OR HAS NEVER STARTED A SERIES - - 3 DOSES ARE ACCEPTABLE FOR CERTIFICATION.

PART III: IF THE CHILD CANNOT MEET THE ABOVE CRITERIA, INDICATE REASON AND SIGN ACCORDINGLY.

① THE PHYSICAL CONDITION OF THE ABOVE NAMED CHILD IS SUCH THAT IMMUNIZATIONS WOULD ENDANGER LIFE OR HEALTH.

SIGNED ______________________ DATE ______________
(PHYSICIAN)

② PARENT OR GUARDIAN OF THE ABOVE NAMED CHILD ADHERES TO A RELIGIOUS BELIEF WHOSE TEACHINGS ARE OPPOSED TO SUCH IMMUNIZATIONS.

SIGNED ______________________ DATE ______________
(PARENT OR GUARDIAN)

③ BECAUSE OF FINANCIAL CIRCUMSTANCES, I REQUEST AND GIVE PERMISSION TO THE LOCAL HEALTH DEPARTMENT OR THEIR REPRESENTATIVE TO ADMINISTER IMMUNIZATIONS AS PRESCRIBED BY THE COLORADO BOARD OF HEALTH TO THE CHILD NAMED ABOVE.

MY CHILD HAS ALREADY RECEIVED THE FOLLOWING IMMUNIZATIONS:

DTP	ORAL POLIO	MEASLES	RUBELLA
NUMBER	NUMBER	YEAR	YEAR

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SIGNED ______________________ DATE ______________
(PARENT OR GUARDIAN)

PM EPI (V) 95 (4-76-20000)

COLORADO DEPARTMENT OF HEALTH -- SCHOOL IMMUNIZATION LAW

LIST OF NON-COMPLIERS

This is a list of children who have not returned a properly completed Certificate of Immunization. (Number of children listed should match those in the NON-COMPLIER category of the Certification Summary form.)

NOTF: Prepare in duplicate. Send original to the Colorado Department of Health, Immunization Program, 4210 E. 11th Ave., Denver 80220, on or before NOVEMBER 15 along with the CERTIFICATION SUMMARY.

Keep the duplicate as a working copy. By April 1, send the duplicate copy to the Colorado Department of Health to report children who have become fully immunized, have moved or withdrawn since the first report.

School or Facility____________________ District__________

Address____________________ Phone__________

City Zip County

Complete for NOVEMBER 15 Report				Complete for April 1 Report	
CHILD'S NAME	PARENT'S NAME	ADDRESS & ZIP	PHONE	DATE CERTIFICATE COMPLETED	DATE MOVED OR WITHDRAWN

PM EPI (V) 98 (Rev 5-75-800)

COLORADO DEPARTMENT OF HEALTH
SCHOOL IMMUNIZATION LAW

CERTIFICATION SUMMARY

School or Facility________________________________ District__________

Address____ Phone______
City Zip County

	NEW CHILDREN	OUT-OF-STATE TRANSFEREES (Grades 1-6 only)	TOTALS
	Number	Number	
FULLY IMMUNIZED (Part II, all required immunizations completed)			
MEDICAL CONTRAINDICATIONS (signature on Part III, #1)			
RELIGIOUS OBJECTIONS (signature on Part III, #2)			
SIGNED PERMISSION (signature on Part III, #3)			
NON-COMPLIERS (no form, incomplete, in-process)			
TOTAL			

Send this form together with the LIST OF NON-COMPLIERS to the Colorado Department of Health, Immunization Program, 4210 E. 11th Ave., Denver 80220 by NOVEMBER 15.

____
(Name of person completing this form)
PLEASE PRINT

PM EPI (V) 97 (Rev 5-75-30)

TIPS FOR HELPING THE PARENT

A. Parents should receive a Certificate of Immunization from the child's school or facility. Certificates are also available at any local health department or physician's office.

B. Parent should have child's immunizations certified by a private physician or local health department from their records.

C. If a child cannot meet minimum requirements shown on Certificate of Immunization and he needs some immunizations to qualify for school entry, parent should arrange to have them completed ahead of time with local health department or private physician.

D. If all immunizations have been certified, parents return the Certificates of Immunization to school.

E. If parents have no immunization record nor a local doctor--but child had some immunizations, they should contact 1) their original source of care, if possible, for record or 2) a local physician, health department or public health nurse for assistance in completing required immunizations.

F. If parents already have a health record for their child showing dates of immunizations received (green medical I.D. card, military record, International Certificate of Vaccination, family health book or baby book) -- they should take health record to school at registration time for validation by school official on the Certificate of Immunization.

G. If child is in the process of receiving immunizations at the time of school entry, parents should request a signed and dated statement from their physician on his letterhead or prescription pad or from local health department (if it is administering shots) to that effect. The statement should be presented to the school in lieu of the Certificate of Immunization. (Physician should retain Certificate of Immunization and validate it as soon as child completes required immunizations.) Parent must submit completed certificate to school no more than four months later.

H. If child has a physical condition whereby immunizations are medically contraindicated or would be harmful to his health, parent can have physician sign item (1) under Part III.

I. If family adheres to a religious belief opposed to such immunization, parent should sign item (2) under Part III.

J. If parents cannot afford getting immunizations for child, they may grant permission for these to be administered by the local or state health department, public health nurse or school nurse by signing item (3) under Part III.

NOTE

Child may not need ALL shots. Therefore parents should be urged to bring along any immunization record of shots child has received and present to school authorities when entering child in school. These records will be helpful in determining what additional shots are needed to bring child into compliance.

FOLLOW-UP RESPONSIBILITIES

Responsibilities of State Health Department

A. The State Health Department will send letters to the parents of each noncomplying child asking for compliance. Parents will be requested to submit the properly completed Certificate of Immunization to the school or facility where their child is enrolled.

B. The State Health Department will record statistics as the Certification Summaries are received and will compile a preliminary and final report. The preliminary and final report, as well as other reports requested by a school or facility, will be made available upon request.

Responsibilities of Local Health Department or Public Health Nurse

A. Article 66-40-6 of the law, regarding immunization of indigent children, states "The local health department, a public health or school nurse (under the supervision of a licensed physician), or the (State) department of health in the absence of a local health department or public health nurse shall, at public expense to the extent that funds are available, provide the immunizations required by this article to each pupil whose parents or guardians cannot afford to have the pupil immunized and who have not been exempted."

Consequently, a local health department or public health nurse must work closely with each school in somehow providing immunizations for the "signed permission" children, reservoirs of noncompliers, etc. The State Health Department will provide consultation and assistance in setting up special clinics, ways of immunizing children on a one-to-one basis, if need be, or -- all other resources lacking -- will step in and do a "mop up" clinic. This includes children in child care facilities as well as elementary schools.

NOTE

> All vaccines and jet injector guns, if warranted, will be supplied by the Colorado Department of Health through the local public health office.

B. The local health department or public health nurse should serve as coordinator of these activites.

C. Consultation for all immunization activities is available from the State Health Department's Disease Control Representatives. See page for their names, phone numbers and counties served.

Responsibility of School or Facility

A. "In-process" children should be followed up to assure completion of immunizations and that a valid Certificate of Immunization is returned to school within four months.

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B. School's designated personnel should also be making arrangements with the local public health nurse, local health department, medical society or State Health Department Disease Control Representative to provide immunizations for noncompliers (if they exist), the "signed permission" children, and others -- such as "in-process" children and preschoolers (who will eventually have to meet the school entry requirements).

COLORADO DEPARTMENT OF HEALTH
Disease Control Representatives

Northeast Area

Counties Served: Larimer, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma.

Weld County Health Department 353-0540, ext. 214
1516 Hospital Road
Greeley, Colo. 80631

Central East Area

Counties Served: Chaffee, Cheyenne, Custer, Elbert, El Paso, Fremont, Kit Carson, Lake, Lincoln, Park, Teller.

El Paso County Health Department 475-8240, ext. 298
501 N. Foote Avenue
Colorado Springs, Colo. 80909

Southeast Area

Counties Served: Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo.

Pueblo City-County Health Department 544-6031
151 Central Main
Pueblo, Colo. 81050

Northwest Area

Counties Served: Delta, Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, Summit.

Mesa County Health Department 243-9200
515 Patterson
Grand Junction, Colo. 81501

Southwest Area

Counties Served: Alamosa, Archuleta, Conejos, Costilla, Dolores, Gunnison, Hinsdale, La Plata, Mineral, Montezuma, Montrose, Ouray, Rio Grande, Sagauche, San Juan, San Miguel.

San Juan Basin Health Department 247-5702
Box 140
Durango, Colo. 81301

Central Metro Area

Counties Served: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Gilpin, Jefferson.

Colorado Department of Health 388-6111, ext. 234
4210 East 11th Avenue
Denver, Colo. 80220

Handicapped Children's Educational Act
(the health component)

The Rules for the Administration of the Handicapped Children's Educational Act, which were adopted by the State Board of Education on August 12, 1976, and approved by the attorney general on November 1, 1976, were distributed by the Colorado Department of Education and became effective December 14, 1976.

In the Rules there is a health component that all school health personnel should be aware of. Sections of the Rules will be quoted in the following paragraphs. However, it is highly recommended that a complete copy of these Rules be obtained from your school district, or the Colorado Department of Education, to fully understand this Handicapped Children's Educational Act.

The Rules state that:

> *Appropriately qualified professional shall complete the assessment procedures appropriate to the suspected handicapping condition, as indicated below, in sufficient scope and intensity to determine the level of the child's handicap, if any, and to identify the nature of the child's special educational needs. (HCEA 2220-R-3.03(5))*

	SUSPECTED HANDICAPPING CONDITION							
ASSESSMENT PROCEDURE	Physical Impairment	Vision	Hearing	Limited Intellectual Capacity	Emotional/ Behavioral	Perceptual/ Communicative	Speech	Multiple
Vision/Hearing Screening	M	M	M	M	M	M	M	*
Educational Assessment	M	M	M	M	M	M	O	
Developmental History	M	R	R	M	M	M	R	
Adaptive Behavior	R	R	R	M	M	M	R	
Health History and Current Health Status	M	R	R	R	R	R	O	
Vision Assessment	O	M	R	O	O	O	O	
Hearing Assessment	O	R	M	O	O	O	O	
Speech and Language Assessment	O	O	M	R	O	M	M	
Psychological Assessment	R	R	R	M	M	R	O	
Other Agency Information	O	O	R	R	R	O	O	

**For a child with multiple suspected handicaps, the assessment procedures shall be those indicated for each of the individual suspected handicapping conditions.*

M = Mandatory R = Recommended O = Optional

(HCEA 2220-R-3.03(5)(a))

Health history and current health status includes information relating to the child's birth history, health habits, family health, significant illnesses, accidents, injuries or operations, medications used, screening results, height, weight, and body build, medical observations, review of systems and source of medical care. (HCEA 2220-R-3.03(5)(a)(ii))

With reference to the table above: (HCEA 2220-R-3.03(5)(b))

"Mandatory" means that the assessment procedure is expected to provide crucial information in 100 percent of the cases referred for assessment and staffing in the suspected category of handicapping condition. All children placed in programs for a particular handicapping condition shall have received the assessments indicated as "Mandatory" for that handicapping condition. (HCEA 2220-R-3.03(5)(b)(i))

"Recommended" means that the assessment procedure can be expected to provide highly relevant information in up to 80 percent of the cases referred for assessment and staffing in the suspected category of handicapping condition. Professional judgment will be required to determine the necessity for the assessment in individual cases. The record shall indicate the reasons for not completing "recommended" procedures when this decision is made. (HCEA 2220-R-3.03(5)(b)(ii))

"Optional" means that the procedure is unlikely to provide additional information in most instances, but may be necessary in up to 20 percent of the cases referred for assessment and staffing in the suspected category of handicapping conditions. Professional judgment will be required to determine the necessity for the particular procedure in individual cases. (HCEA 2220-R-3.03(5)(b)(iii))

In Exhibit VII there is a sample of a form that can be used to obtain the health history and current health status.

The school nurse is not a mandatory person of the HCEA staffing team. However, the school nurse is included under the following statement in the Rules:

One or more of the following professional personnel shall be included as governed by the number and kinds of assessment procedures completed in each case, to interpret specialized assessment information which he or she may have obtained about the child, or to provide other pertinent information. (HCEA 2220-R-3.04(2)(g))

A school nurse 3.04(2)(g)(i).

Some school districts have appointed the school nurse as a permanent member of the staffing team. This is entirely appropriate in those districts and recommended whenever possible. The school nurse may be the one person of the school team who has a comprehensive overall health evaluation of the child, including knowledge of the home situation and family concerns.

In Exhibit VIII there is a sample form that can be used to summarize the health history and current health status. This type of information should be sent to the staffing team by the school nurse whenever a student is being staffed and she is unable to attend.

In the reimbursement provisions for the H.C.E.A. it needs to be strongly stressed that the health component reimbursement is not for a total school health program. It is only for those services required by the H.C.E.A.

The Rules state in relation to the reimbursement provision that:

> *Support staff will be approved on the basis of the following planning ratios, or as otherwise justified by the administrative unit. These planning ratios are to be used only in predicting the staffing level required to serve only handicapped children, and should not be interpreted as affecting regular education programs. (H.C.E.A. 2220-R-8.01(2)(b))*

The school nurse ratio stated in the table following the above statement is "one school nurse : 4,000 average daily membership." This means that one FTE school nurse position is reimbursed for every 4,000 regular students, but this school nurse serves only those students among that 4,000 who are eligible for the H.C.E.A.

The Rules go further in this section to state that:

> *Administrative units may contract with mental health clinics and public health agencies for certain services. (HCEA 2220-R-8.01(2)(c))*
>
> *The level of staff provided by such contracts will be approved on the basis of the same planning ratios applied to regular employees of the administrative unit. (HCEA 2220-R-8.01(2)(i))*
>
> *Only that part of agency contracts which provides for the reimbursable expenses of teacher referral of children, case finding and assessment, staffing committee participation, teacher and parent counseling and consultation will be approved for reimbursement. (HCEA 2220-R-8.01(2)(c)(ii)*

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The Colorado Department of Education is only able to reimburse administrative units for the H.C.E.A. with the funds appropriated by the Colorado Legislature for this specific purpose. As yet, they have not been fully funded. Therefore, the rules state:

> *In the event appropriations shall be insufficient to cover reimbursements provided for in the Act, the Department will notify administrative units of the estimated proration factor periodically. (HCEA 2220-R-8.06)*

Overall School Health Policies for Public Health School Nurse Services

When a county public health nurse, or local health department, provides the school health services to the school district, there should be written policies agreed to by the school superintendent, school board, and public health nurse or local health department. If a county public health nurse is involved, it may also require the approval of the county commissioners.

Such an agreement should include a brief philosophy, objectives, general policies, activities of the public health school nurse, and resources available to the school nurse and school district.

Exhibit IX is an example of school policies for a public health school nurse in a limited school health program. The activities of the public health nurse could be increased for a more expanded school health program.

Exhibit X is a sample contract for school health services furnished by the public health nurse.

Exhibit XI is a sample contract for school health services as required by the Handicapped Children's Educational Act.

EXHIBIT II

First Aid Supply Recommendations

1. Soap and water
2. Band aids (water proof, nonmedicated)
3. Sterile gauze (3" x 3" and 4" x 4"
4. Roller gauze bandage (2" x 3")
5. Adhesive tape (1" and 2" widths)
6. Triangle bandages
7. Tongue depressors in closed containers
8. Sterile petroleum (Vaseline)
9. Applicator sticks in closed containers
10. Aromatic spirits of ammonia
11. Cotton balls
12. Thermometers and holders
13. Paper towels
14. Splints
15. Ice bags
16. Paper cups
17. Safety pins
18. Tweezers
19. Bandage scissors
20. Low flat cots with washable surface (no pillows, sheets, blankets)
21. Blankets - for emergency use in case of shock
22. Soda - for insect bites.
23. Ipecac or Epson Salts for poison antidotes
24. Ice bag and hot water bottle

EXHIBIT III

Accident Report

Date ______________________________ Time ______________

Name ______________________________ Birth Date __________

Address ____________________________ Phone ______________

School _____________________________ Grade ______________

Teacher ____

Description of accident (include time and place) ______________
____
____
____
____
____

Name of adult present at time of accident ______________________
Witness present at time of accident ___________________________

First aid given (describe) _____________________________________
____
____
____
____

Time given _____________________ By whom ______________

Time parent notified _______________ By whom ______________

Student was sent to: home________ doctor ________ hospital ________

Days absent from school due to accident_________________________

Follow-up information obtained _________________________________
____
____

Principal's signature ____

School nurse's signature _______________________________________

Other comments ____
____
____
____

EXHIBIT IV

Permission for Medication

Name of student ______________________________

School ______________________ Grade __________

Teacher ______________________________

Medication ______________ Dosage ______________

Purpose of medication ______________________________

____

Time of day medication is to be given ______________

Possible side effects ______________________________

____

Anticipated number of days it needs to be given at school __________

____

Date ______________ ______________________
Signature of Physician

I hereby give my permission for ______________________
to take the above prescription at school as ordered. I understand that
it is my responsibility to furnish this medication.

Date ______________ ______________________
Signature of Parent or Guardian

Note: The prescription medication is to be brought to school in a container appropriately labeled by the pharmacy, or physician, stating the name of the medication and the dosage.

EXHIBIT V

COLORADO DEPARTMENT OF HEALTH

SCHOOL ENTRY IMMUNIZATION LAW

Instruction Sheet - September, 1976

Step 1. Collect blue and white Certificate of Immunization from children entering your facility, for the first time, before November 1, (This also includes children transferring to your school from out-of-state, in grades 1 - 6.)

Step 2. Check each Certificate of Immunization to make sure it is properly completed. A certificate is complete if one of the following conditions is met:

1) All required immunizations are complete and there is a signature under Part II of the certificate.

2) There is a signature under Part III, number 1 or 2 of the certificate.

3) There is a signature under Part III, number 3 of the certificate, and previous immunizations are indicated.

Step 3. From the collected slips, prepare the Certification Summary noting numbers of new children in each of the listed categories. List each child in only one category. (Please total each column, across and down.)

Step 4. Compile the List of Noncompliers in duplicate. The number of noncompliers listed must equal the number of noncompliers indicated on the Certification Summary. Keep the duplicate list as a working copy.

Step 5. By November 15, the Certification Summary along with the original List of Noncompliers should be sent to:

(FIRST REPORT)

Immunization Program
Colorado Department of Health
4210 E. 11th Avenue
Denver, Colorado 80220

(Colorado Department of Health will contact all noncompliers urging completion of immunizations and instructing them to deliver completed certificates to their school.)

Step 6. Students entering after November 1, are also required to submit a completed Certificate of Immunization, and every effort should be made to bring these children into compliance with the law. However, DO NOT add names to the existing List of Noncompliers.

Step 7. As noncomplying students turn in Certificates of Immunization or withdraw from your facility, indicate on your duplicate working copy of the List of Noncompliers the date of compliance or date withdrawn.

Step 8. (FINAL REPORT) By April 1, the duplicate copy of the List of Noncompliers, indicating date of compliance or date withdrawn for each listed child, should be sent to the Immunization Program, Colorado Department of Health.

PM EPI (V) 104 (Rev-9-76)

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RECOMMENDED IMMUNIZATION AND TUBERCULIN TESTING SCHEDULE

COLORADO DEPARTMENT OF HEALTH

July 1977

COLORADO MEDICAL SOCIETY

PRIMARY IMMUNIZATIONS FOR NORMAL INFANTS

AGE	VACCINES	COMMENTS
2 MONTHS	DTP & POLIO	DTP - 0.5 ml Diphtheria, Pertussis and Tetanus (Adsorbed type) administered intramuscularly. POLIO - Trivalent Oral Polio Vaccine (TOPV)
4 MONTHS	DTP & POLIO	
6 MONTHS	DTP	
15 MONTHS	MEASLES (M) MUMPS (M) RUBELLA (R)	One dose (0.5 ml) of combined antigen administered subcutaneously. If antigens given separately they may be administered simultaneously at different sites or they must be administered one month apart.
15 - 18 MONTHS	DTP & POLIO	These doses are considered to be an integral part of the primary immunization series.

BOOSTER IMMUNIZATIONS

AGE	VACCINES	COMMENTS
4-5 YEARS	DTP & POLIO	Should be given prior to school entry.
EVERY 10 YEARS	TD ADULT	0.5 ml should be administered intramuscularly at ten-year intervals to persons age six and above.

PRIMARY IMMUNIZATIONS FOR CHILDREN NOT IMMUNIZED IN INFANCY

	1 THRU 5 YRS.	6 YRS. OF AGE & OVER
FIRST VISIT	DTP, TOPV, MMR*	TD ADULT, TOPV, MMR
2 MONTHS AFTER 1ST VISIT	DTP, TOPV	TD ADULT, TOPV
4 MONTHS AFTER 1ST VISIT	DTP	
6-12 MONTHS LATER	DTP, TOPV	TD ADULT, TOPV
EVERY 10 YEARS THEREAFTER	TD ADULT	TD ADULT

* If less than 15 months of age, delay MMR until child is 15 months old.

COLORADO SCHOOL IMMUNIZATION LAW

Children entering school in Colorado for the first time must have received the following immunizations:

	PRESCHOOL Age 0-4	ELEMENTARY SCHOOL Age 5-12
DTP/TD	3 doses	4* doses
Polio	3 doses	4* doses
Measles	1 dose **	1 dose
Rubella	1 dose**	1 dose

* If a child is just starting or completing initial series at time of school entry, 2 doses of DTP/TD and polio are acceptable for certification.

** Children younger than 15 months are exempted.

TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

HISTORY OF TETANUS IMMUNIZATIONS (Doses)	CLEAN, MINOR WOUNDS TD	CLEAN, MINOR WOUNDS TIG[1]	ALL OTHER WOUNDS TD	ALL OTHER WOUNDS TIG
Uncertain	Yes	No	Yes	Yes
0-1	Yes	No	Yes	Yes
2	Yes	No	Yes	No[2]
3 or more	No[3]	No	No[4]	No

1. T.I.G. - Tetanus Immune Globulin
2. Unless wound more than 24 hours old
3. Unless more than 10 years since last dose
4. Unless more than 5 years since last dose

NOTE: Substitute DTP vaccine for children under six years of age.

TUBERCULIN TESTING

Need for and frequency of tuberculin tests depend on risk of exposure and the prevalence of tuberculosis in the population group. Testing of small children, if indicated, should be at the time of, or preceding, the measles immunization.

SCHOOL, NURSING HOME, AND HOSPITAL EMPLOYEE TESTING
Provide a tuberculin skin test to all employees at time of hiring; provide chest X-ray to those who have a positive reaction to the skin test - to develop a baseline of information. Policies for repeating skin tests should be determined by the risk of acquiring a new infection.

PRECAUTIONS AND CONTRAINDICATIONS

DTP (1) Use with caution if history of adverse reaction to DTP or TD; fractionated doses of DTP may be given; (2) Moderate to severe febrile illness*; (3) Steroid therapy.

POLIO (1) Not routinely recommended for those over 18 years of age; (2) Moderate to severe febrile illness*; (3) Persistent vomiting or diarrhea.

WHETHER MEASLES, MUMPS, AND RUBELLA VACCINES ARE GIVEN INDIVIDUALLY, SIMULTANEOUSLY, OR IN COMBINED FORM, THE FOLLOWING PRECAUTIONS AND CONTRAINDICATIONS APPLY:

MEASLES MUMPS RUBELLA (1) Moderate to severe febrile illness*; (2) Leukemia or other malignancy; (3) Steroids or other immunologic depressant; (4) Immune serum globulin administered in previous 12 weeks; (5) Hypersensitivity: Live vaccines produced in chick embryo cell culture have not been reported to be associated with hypersensitivity reactions and can be given to all who need them; however, vaccine should not be given to persons hypersensitive to vaccine components, such as trace amount of particuar antibiotics (see manufacturer's label); (6) Untreated tuberculosis note: tuberculin skin test can be given on same day measles vaccine is given; if not given on same day, TB skin test should be delayed for six weeks; TB skin test need not be a prerequisite to vaccination in community-wide programs; (7) Pregnancy: on grounds of a theoretical risk to the developing fetus, live attenuated virus vaccines are not generally given to pregnant women; if, however, there is risk of exposure to measles, there is no evidence that the vaccine cannot be given safely and effectively; (8) Child-bearing age females should be using approved birth control method prior to and 3 months following rubella immunization.

*Minor infections such as those characterized by cough, runny nose or low grade fever are not contraindications for immunization.

SPECIAL NOTES

INTERRUPTION OF IMMUNIZATION SCHEDULE —— Interruption of recommended schedule for DTP or polio, with a delay between doses, does not interfere with the final immunity achieved, nor does it necessitate starting the series over again, regardless of the length of time elapsed.

MEASLES REVACCINATION —— The following children should be revaccinated: (1) Those who received inactivated vaccine; (2) Those vaccinated prior to age 1; (3) Those with doubtful immunization history. In face of measles outbreak, infants at risk of exposure may be immunized as early as 6 months of age with a repeat dose at or after age 15 months. Children who received vaccine with immune serum globulin or children whose live vaccine was given at or shortly after 12 months, but before 15 months, need not be recalled for reimmunization. Speed in implementing outbreak control programs is essential in preventing measles spread. Records may be available; however, it is best to immunize children whose immunity status is in doubt as quickly as possible, rather than wait for exhaustive record searches.

SIMULTANEOUS ADMINISTRATION OF CERTAIN LIVE VIRUS VACCINES —— The U.S. Public Health Service Advisory Committee on Immunization Practices has approved simultaneous administration of combined measles/mumps/rubella vaccines with trivalent oral polio vaccine. It is possible for a child to receive DTP, TOPV and measles/mumps/rubella vaccines in one visit.

EXHIBIT VII

HEALTH ASSESSMENT - STUDENT INFORMATION FORM

NAME OF REFERRAL ____________________ DATE OF BIRTH ____________

PRESENT SCHOOL ____________________ GRADE ____________

ADDRESS ____________________ PHONE ____________

INTERVIEWER ____________________ PLACE OF INTERVIEW ________

CURRENT PROBLEM ______________________________________

____

PERSON(S) INTERVIEWED: ______________ DATE OF INTERVIEW ________

MOTHER ONLY ☐ FATHER ONLY ☐ BOTH ☐

OTHER ☐ (please specify) ______________________________

FATHER'S NAME ______________ MOTHER'S NAME ______________

OCCUPATION ______________ OCCUPATION ______________

PARENT RELATIONSHIP TO CHILD: NATURAL ☐ ADOPTED ☐

LIVING WITH: BOTH PARENTS ☐ FATHER ONLY ☐ MOTHER ONLY ☐

OTHER ☐ (please specify) ______________________________

MAJOR LANGUAGE IN HOME ______________________________

FAMILY PHYSICIAN ______________ DATE OF LAST PHYSICAL ________

SCHOOL NURSE - DR. CONTACT ______________________________

HEALTH HISTORY:

1. PREGNANCY AND BIRTH:

A. PRENATAL

(1) Approximate age of mother ________ father ________

(2) Birth order ______________ Birth weight ________

(3) Length of pregnancy ______________________

(4) Any significant illnesses, symptoms (bleeding, cramping, etc.) or accidents during pregnancy? ______________

(5) Unusual exposure to irradiation or medications? ________

(6) Any above problem during other pregnancies? ________

B. PERINATAL

(1) Problems during labor and delivery

(2) Type of delivery

(3) Any above problems during other pregnancies

2. DEVELOPMENTAL HISTORY (indicate any abnormalities):

A. NORMAL OR ABNORMAL DEVELOPMENTAL LANDMARKS (if possible, use approx. age)

CRAWLING ________________ WALKING ____________________

TALKING ______________ BOWEL & BLADDER TRAINED _____________

B. PHYSICAL GROWTH (note any abnormalities)

C. GENERAL GROWTH PATTERNS OF FAMILY (note any abnormalities)

3. CURRENT HEALTH HABITS & OTHER BEHAVIOR:

EATING______________________ SLEEPING________________

DRESSING____________________ ENURESIS _______________

THUMBSUCKING________________ NAIL BITING_____________

NUTRITION___________________ EXERCISE________________

FEARS_______________________ DAYDREAMING_____________

DRUG EXPERIENCE_____________ ALCOHOL EXPERIENCE______

TANTRUMS____________________ EYE BLINKING____________

4. PERSONALITY TRAITS:

GENERALLY: HAPPY _______________ SAD__________________

AGGRESSIVE__________ SHY__________________

GENEROUS____________ JEALOUS______________

RESTLESS____________ CALM_________________

GOOD NATURED________ IRRITABLE____________

KIND________________ DEFENSIVE____________

CRIES EASILY________

PLAYS: INDOORS_________ OUTDOORS_______________

MAKES FRIENDS EASILY______ AGES_________ INTERESTS____________________

5. SIGNIFICANT HEALTH PROBLEMS, ILLNESS, AND COMPLAINTS:

A. SIGNIFICANT HEALTH PROBLEMS

(1) Chronic conditions (asthma, allergies, seizures, diabetes, etc.)

(2) Recurrent acute conditions

(3) Handicaps

6. INFORMATION REGARDING PAST AND PRESENT MEDICATIONS AND IMMUNIZATIONS:

A. WHAT MEDICATIONS, HOW MUCH, WHEN AND WHY TAKEN ANY REACTIONS?

7. ACCIDENTS, INJURIES, AND OPERATIONS:

A. ANY UNUSUAL EXPERIENCE WITH ACCIDENTS AS TO NATURE, EXTENT OR FREQUENCY?

B. INJURIES - (include any history of head injuries or causes of unconsciousness)

C. OPERATIONS (what and when)

8. FAMILY HEALTH HISTORY:

A. AGES AND STATE OF HEALTH OF ALL IMMEDIATE FAMILY MEMBERS. ANY HISTORY OF STILLBIRTHS, MISCARRIAGES, OR ABORTIONS.

B. FAMILY HISTORY OF SCHOOL PROBLEMS.

NURSING ASSESSMENT

1. SCREENING - VISION, HEARING, AND OTHER AS INCLUDED IN PROGRAM OR APPROPRIATE FOR STUDENT:

2. HEIGHT AND WEIGHT AND TYPE OF BODY BUILD (percentile from growth chart):

3. DIRECT OBSERVATION, ANY GENERAL NURSING OBSERVATION OR ABNORMALITIES OF STUDENT:

4. REVIEW OF SYSTEMS:

   A. EENT: Double vision, tearing, blurring, eye discharge, crossed eyes, colds, sore throats, earaches, rhinitis, hearing, smelling, taste, mouth breathing, snoring, sneezing, nosebleeds, dental problems.

   B. CARDIO RESPIRATORY: Shortness of breath, wheezing, coughing, chest pain, edema, cyanosis on exertion, cold extremities.

   C. GASTRO INTESTINAL: Vomiting, diarrhea, constipation, abdominal pain, jaundice, bowel control, g.i. bleeding, nausea, pinworm symptoms.

   D. GENITOURINAL: Frequency, pain, hematuria, stream, vaginal discharge, menstrual history, abnormalities of penis and testes, bladder control.

   E. NEURO-MUSCULAR: Tingling, numbness, headaches, dizziness, seizures, tremors, twitching, blackouts, postural, deformities, gait, personality changes, unconsciousness, general speech.

   F. SKIN: Itching, irritation, perspiration, growths, rash, excessive dryness, unusual skin color, nail or hair problems.

5. IMPRESSION AND RECOMMENDATIONS:

EXHIBIT VIII

Recommended Form for
PLACEMENT STAFFINGS AND ANNUAL REVIEW
School Health Summary

Student____ Birth date______________

School____ Grade__________________

Review of School Health Records:
(Record any past medical problems that are of significance.)

Current Findings or Concerns:
(Include results of vision, hearing, height and weight screening, as well as summary of any significant findings on physical examination or health assessment.)

Recommendations:
(What type of follow-up care is needed?)

Date________________________________ School Nurse______________________________

EXHIBIT IX

An Example of SCHOOL POLICIES for a School Health Program as Provided by a Public Health School Nurse

PHILOSOPHY

We believe that the school environment is second only to the home environment in its effect upon health and development of the child and youth. Health taught at the school setting may have a lifelong influence.

OBJECTIVES

1. To identify health related problems or handicapping conditions and assist in their remediation.

2. To serve as a resource person and consultant to the faculty and to the student body.

3. To assist with adjustment to existing health problems.

4. To maximize school attendance.

GENERAL POLICIES

1. Primary responsibility for health of school child should rest with his parents.

2. Emergency Care:

   a. Qualified First Aid school personnel will give immediate care in case of accident or sudden illness. Refer to Emergency Care Flip Chart. Available from Department of Education.

   b. All school personnel will be encouraged to have Red Cross First Aid training, or equivalent, with at least two in each building designated to administer First Aid.

   c. At the time of the emergency, the school has the responsibility for -

      (1) Notifying the child's parents or guardian or if these cannot be reached, for following directions given on the child's emergency card. These cards will be updated annually by the school.

      (2) In extreme cases, getting the child under professional care with or without the family's permission.

(3) Accurate recording on child's health record -

    (a) the nature of emergency
    (b) how it happened
    (c) action taken and by whom
    (d) be sure to record date and time

d. In the absence of family transportation or ambulance service, qualified school personnel, as designated by the principal, may transport the sick or injured to his home, physician's office, or hospital. If the child is going home, the school will first ascertain that a responsible person is at home to receive him.

e. Each school will have a First Aid kit or cupboard with contents as recommended by the American Red Cross training. The public health nurse will review this cupboard or kit and make recommendations.

3. The school administration is responsible for exclusion of children with communicable diseases, acting on recommendation and guidance from the public health nurse and/or medical advisor. The public health nurse shall be notified of all children so excluded. Refer to Communicable Disease Flip Chart. Available from Department of Health.

4. Immunization: There was an immunization law passed by the Colorado Legislature, effective July 1, 1974. Please refer to the rules and regulations for interpretation of the law on file in each school.

5. No medication will be administered by any school personnel, including the public health nurse, except on written orders from a physician and in compliance with the following school regulations:

    a. When it is necessary for a student to be assisted with medication at school, parents should ask the physician to write a request indicating name of medication, the dosage, purpose for medication, time of day to be given, the possible side effects and the anticipated length of time to be taken at school. School administration or public health nurse may verify directions by contacting the physician.

    b. Medicine should be in the pharmacy labeled bottle including, child's name, name of medication, dosage, doctor's name and date.

    c. Older children, who are mature enough and capable of taking their own medication, may bring a daily dose with them. Information on children receiving such medication should be recorded including complying with section 5.a.

    d. Schools do not allow students giving medication to other students. This includes aspirin, cough drops, etc. In the event this is done, the school will not be responsible for any complications arising from this action.

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e. School district and/or the public health nurse has the authority to question if it is really necessary to give medication during school hours.

6. A school health record will be provided by the school district and maintained by the secretary and public health nurse on every child to provide continuity for care of the child and avoid duplication.

7. Physical exams for secondary interschool athletic activities shall be done in compliance with the recommendations of the Colorado High School Activities Association.

8. All school personnel will be urged to have a medical evaluation before initial employment and at least every three years thereafter.

9. Review of school health policy and programs shall be done by the school administrators, nurse, and school board members at regular intervals as indicated by need.

ACTIVITIES OF PUBLIC HEALTH SCHOOL NURSE

1. Screenings:

Vision -

a. Grade as determined public health nurse (see Chapter VII).
b. All teacher referrals including students to be staffed.
c. All children with known uncorrected loss.

Hearing -

a. Grade as determined by public health nurse (see Chapter VII).
b. All teacher referrals including students to be staffed.
c. All referred from school screening/treatment provided by HCP or private physician.
d. All children with a known loss.

Tuberculosis -

a. Test school enterers if reaction rate above 1%.
b. Test new enterers each 3-4 years to determine or confirm reaction rate.
c. Test new employees not previously tested within the past year.

2. Clinics:

a. Preschool Health Evaluation
b. Immunization

3. Individual nurse-teacher conference as deemed necessary by public health nurse or teacher. (See Chapter IV)

4. Health education consultation.

5. Counseling - individual or group basis.
6. Home visits to coordinate care between family and school.
7. Provide health information to secretaries for recording on permanent school health records.
8. Initiate or assist with inservice education on health topics to school personnel.
9. Attend staffings when possible, and submit written health summary as determined by public health nurse on those students recommended for placement into the special education program.
10. At the end of the school year, submit a summary and evaluation of the year's findings.

RESOURCES

1. Currently available:
   - a. Child (including peers)
   - b. Parents
   - c. Teachers
   - d. Mental Health Clinic
   - e. Child Welfare
   - f. Community Service Groups
   - g. Colorado Department of Health - Handicapped Children's Program
   - h. School Administration
   - i. Family physician and other health related personnel
   - j. News media
   - k. State Tuberculosis Program
   - l. State Epidemiology Program
   - m. Hospitals and other diagnostic and treatment facilities
   - n. BOCES
   - o. Nursing Consultants
2. Needed:
   - a. Comprehensive K-12 health curriculum guideline
   - b. Increased mental health services
   - c. Multi-disciplinary inservice - on identification and treatment of emotional and physical problems of school-age child.
   - d. Records regarding health status of school personnel kept on file in individual school.

Date signed: School official:

School Superintendent

School Board Chairman

Public Health Nurse

EXHIBIT X

Sample Contract
School Health Services

For Public Health Nursing Services to the school children of __________ ________________ County, the __________________________ School District agrees to reimburse _____________________ County $_________________.

THE UNDERSIGNED AGREE TO THE FOLLOWING CONDITIONS:

1. The term of this agreement shall be from _________________ 1, 197__, to and including _________________________ 31, 197__.

2. This agreement may be cancelled and terminated by either party hereto but that the party desiring to terminate or cancel must give written notice of its intention thirty (30) days prior to the date of cancellation.

3. The amount of nursing service to the school children of ______________ County shall be no less than ____ for the duration of the agreement.

4. The Nursing Supervisor from the ____________________ County Nursing Service shall have the authority for nursing administration, supervision, and periodic evaluation of the quality and quantity of nursing service. The types of services in the schools, routine and special reports to be submitted, will be determined by joint conferences with the School District Superintendent (or his designate), the Nursing Supervisor, and the Public Health Nurses.

5. Prior to the employment of a nurse, Applications for Employment must be submitted to the Nursing Section of the_________________ County Nursing Service for review and approval, based on recommended Personnel Standards. The School Superintendent (or his designate) will be allowed review and approval also.

Reimbursement will be made _________________, based on a sum equal to _________________ of the agreed amount. Monies will be used for salary payments, mileage, and such nursing supplies and equipment as appropriate. Nursing personnel in __________________ County will be employed and paid for (including travel and office expense) by the County.

____
School District Superintendent

____
Chairman, ______________ County Commissioners

Date _________________________

EXHIBIT XI

Sample Contract
School Health Services

For Public Health Nursing Services to the school children of ____________ County, the __________________________ School District __________________ agrees to reimburse __________________ County $__________________________.

THE UNDERSIGNED AGREE TO THE FOLLOWING CONDITIONS:

1. The term of this agreement shall be from __________________ 1, 197__, to and including __________________ 31, 197__.

2. This agreement may be cancelled and terminated by either party hereto but that the party desiring to terminate or cancel must give written notice of its intention thirty (30) days prior to the date of cancellation.

3. The amount of nursing service to the school children of _______________ County shall be no less than ______________________________________ for the duration of the agreement.

4. The Nursing Supervisor from the _______________ County Nursing Service shall have the authority for nursing administration, supervision, and periodic evaluation of the quality and quantity of nursing service. The types of services in the schools, routine and special reports to be submitted, will be determined by joint conferences with the School District Superintendent (or his designate), the Nursing Supervisor, and the Public Health Nurses.

5. Reimbursement under the Handicapped Children's Educational Act will be made for the following services upon referral by school personnel:

    case finding and assessment
    staffing committee participation
    teacher and parent counseling and consultation

6. Prior to the employment of a nurse, Applications for Employment must be submitted to the Nursing Section of the _____________ County Nursing Service for review and approval, based on recommended Personnel Standards. The School Superintendent (or his designate) will be allowed review and approval also.

Reimbursement will be made ________________________, based on a sum equal to ___________________ of the agreed amount. Monies will be used for salary payments, mileage, and such nursing supplies and equipment as appropriate. Nursing personnel in _____________ County will be employed and paid for (including travel and office expense) by the County.

____
School District Superintendent

____
Chairman, ____________ County Commissioners

Date _________________________

CHAPTER IV

NURSING SERVICE IN THE SCHOOLS

Goals and Specific Services

The primary goals of the school nursing service are 1) identify health-related problems or handicapping conditions, 2) provide recommendations in remediation of, or adjustment to, identified health problems, and 3) serve as a resource person and consultant to faculty, student, family, or to the student's health care provider(s).

The population served by the school nurse includes students in kindergarten through the 12th grade. The age groups, recognized by the Colorado Department of Education, are those children between the ages of five years and 21 years, who have not graduated from a 12-year school program.

The services that can be provided by the school nurse are very well described in "The Unique Functions of the School Nurse," printed by the National Education Association, Department of School Nurses. They are listed as:

1. *Assess and evaluate health and developmental status of pupils in order to make a nursing diagnosis and to establish priority for action.*
2. *Interpret health and developmental status of pupils for parents, school personnel, and for pupil.*
3. *Interpret results of medical findings concerning pupil for parents, school personnel, and for pupil.*
4. *Counsel pupil, parents, and school personnel and plan action for eliminating, minimizing, or accepting health problems that interfere with effective learning by pupil.*
5. *Assist persons responsible for pupil's health to find and use appropriate resource material.*
6. *Recommend modifications in the educational program to administrator when health or developmental status of pupil indicates need for such action.*
7. *Serve as health consultant and resource person in health instruction curriculum planning by providing current scientific information from related fields.*
8. *Use direct health services as vehicle for health counseling.*
9. *Serve as liaison between parent, school, and community health matters.*

10. *Serve as a member of placement committee for special educational programs.*

The services that the school nurse actually provides will vary in the individual school district settings according to the specific school needs. They will be dependent on the amount of time the nurse is able to spend in the school health program. For the public health school nurse this is usually determined by the amount of financial reimbursement the public health nurse receives from the school district for the services. If the public health nurses receive no financial reimbursement for the school health services, it is quite possible that the only services available to the school district are vision and hearing screening, help with control of communicable diseases, and consultation on referral basis only.

Functions of the School Nursing Service

Using the preceding statement from National Education Association, Department of School Nurses as a framework, the function of the school nursing service will be divided into 11 areas and discussed. These functions will be guidelines and should be adapted to the individual school health programs as the specific school needs are determined, taking into consideration the amount of nursing time available, the number of students served, and the distance between the schools that one nurse serves.

The ratio recommended by the Colorado Advisory Committee on School Health, organized by the Colorado Department of Education in 1967, is one full-time nurse per 1200-1500 pupils for elementary schools, and one full-time nurse per 1800-2400 pupils for secondary schools.[4] Then in 1972, the National Education Association, Department of School Nurses, recommended the maximum nurse-pupil ratio as one full-time nurse to every 750 pupils.[5]

Based on the role of the school nurse as she functions today, and the previous two statements, the recommended ratio for Colorado schools is one full-time school nurse to every 1300 students for both elementary and secondary schools.

The 11 areas of functions of the school nursing service as described for the purposes of this manual are:

Health Appraisal and Assessment

Physical Examination

Screening Programs

Teacher-Nurse Conferences and Referrals

Health Counseling

Handicapped or Chronically Ill Children

Communicable Disease Control

Mental Health in the Schools

Health Office Management

Health Education

Health School Environment

1. Health Appraisal and Assessments

A health appraisal is the process of determining the total health status of the pupil through such means as parent, teacher, and nurse observations; screening tests; physical fitness tests; study of information concerning the pupil's past health experience; and medical, psychological, and dental examinations. A health appraisal is a cooperative process to evaluate the student's health, but is never an end in itself. It is a starting point in preventing or correcting disabilities.

Ideally, each child when he enters school should have a health assessment done by the school nurse. This may be a kindergarten student entering school for the first time, or a student transferring from another school district. The health assessment is the school nurse's contribution to the total health appraisal. The health assessment consists of a health history and evaluation of current health status. The components of these have already been discussed in Chapter III under health component of the Handicapped Children's Educational Act. From the data gathered during the health assessment the nurse should develop a nursing care plan, set priorities, and determine how she will evaluate the effectiveness of this plan.

These health assessments and total health appraisals are excellent base line data for the student's individual health folder. It can be used for future reference in counseling parents, teachers, and students. Also, if the student is later evaluated for the H.C.E.A. this provides information to build on. Many kindergarten screening programs incorporate the health assessment as part of the information obtained.

2. Physical Examination

Periodic physical examinations by the student's family physician are essential in any preventive health program. It is recommended that these be done four times during the school years: just before entering school and at the 4th, 7th and 10th grade levels. Additional examination should be made whenever a defect is suspected as a result of observation and screenings. (Exhibit XII is a sample form that may be used.)

For students of low-income families, or other selected students, these periodic physical examinations may be done by the school nurse practitioner or a school nurse trained in a course for history and physical examination skills.

Those students representing their schools in inter-school athletics are required to have on file in the school a statement signed by his (her) parents, or legal guardian, and a practicing physician certifying that he (she) has passed an adequate physical examination within the past year and that it is the opinion of the examining physician that he (she) is physically fit to participate in school athletics. (Exhibit XIII lists the disqualifying conditions for sports.)

These physical examinations should be filed in the student's individual health folder. They are part of the total health appraisal for the student. To make them most effective, all of these examinations should be accompanied with health education designed at the student's level of understanding and directed at encouraging children to participate in their own health care.

3. Screening Programs

The school health screening programs assist in identifying those students needing further evaluation by health professionals. Initial screening may not be considered the best use of professional nursing time. However, the nurse should assume the responsibility of organizing these programs and for training volunteers or teachers to do screening procedures. The school nurse may then do the rescreening and at that time should make the decision of which students to refer for further evaluation. It is most important that the school nurse do something with the problem and document that it made a difference to the student.

The criteria for referral and method of nurse follow-up for correction of defects is a very essential part of the screening program. Local medical advisors may wish to help set up referral criteria. Parents and teachers should both be notified of students failing the final screening.

The most common types of screening programs being conducted in Colorado schools are:

a. vision
b. hearing
c. weight and height
d. dental
e. scoliosis
f. tuberculosis skin testing

Procedure for conducting these types of screening programs are discussed in detail in Chapter VII of this manual.

Less common types of screening programs being conducted are:

a. throat cultures
b. ring worm
c. scabies

4. Teacher-Nurse Conference and Referrals

An essential relationship directly affecting the accomplishments of the nursing service in the school is the closeness and continuity of the nurse-teacher association. This association is strengthened through the planned conferences, the informed conferences, group conferences and orientation conferences with new teachers.

The planned conference is apt to be more effective in the elementary school situation rather than the junior and senior high school setting. In the elementary school-age group, health problems are more self-evident and become evident during the day-by-day observation made by the teacher.

With each elementary school teacher, the nurse aims to arrange at least one carefully planned conference a semester (early fall and late spring).

At the planned conference, the nurse should do the following:

- Review each pupil's record in conjunction with teacher's observation interpreting recommendations, medical, dental and so on, for adjustment as indicated for student.
- Plan for those children needing follow-up care. The teacher can be a valuable ally in her contact with the parents, especially through her observation and knowledge of each child's behavior in the class situation.
- Stimulate interest in health teaching, utilizing screening procedures or the apparent needs of the student as an educational experience.
- Help the teacher plan and evaluate classroom health programs, discuss availability of health education material.
- Adopt a plan for notifying teacher of nurse follow-up on individual cases.

The informal conference of nurse and teacher allows for frequent and casual interchange of pertinent information regarding the student.

The group conference can be of advantage in instances where an understanding of development or illness concerns of the children may be a common problem for several teachers. A demonstration and the teaching of vision and hearing testing, information about a new health record form or revision of old forms, new information concerning a current communicable disease, or new regulation for control or preventive procedures are often accomplished best by group discussion.

Orientation conference with new teachers - If there is a planned orientation program developed by the school administration for the new teachers, the nurse concentrates efforts on having the health program effectively presented. If the school has no general plan, the school nurse may ask for several conferences between the new teachers and those personnel involved in the school health program to discuss the purpose of the program.

These conferences are effective in increasing the understanding of the teacher as this relates to possible health problems.

These conferences are effective as a means of implementing teamwork in the school health program.

Each school should have a method by which referrals to the school nurse from the teacher or other school personnel can be made in a systematically arranged manner. The reason for the referral should be specifically stated and the results of the nurse follow-up should be shared with the person making the referral. When it is appropriate, the principal should also be involved in this communications exchange.

Pueblo School District #60 has developed an excellent "Guide for Teachers' Referral to Nurse." (See Exhibit XIV for this guide.)

Several types of forms have been developed by different school districts for teachers' referrals. In some districts the form is on a half sheet of paper and used for a single day. Other districts use the same type of form, clip it in a manila folder, and use it over a period of time. (See Exhibit XV for this form.)

5. Health Counseling

Health counseling is helpful to the students, parents or guardians and school personnel to gain insight into the nature and significance of conditions revealed by various appraisal techniques. The school nurse serves as this health counselor and many times is also the liaison person between the school and home, or other health professionals and the school. A fundamental part of the school nurse's preparation should be knowledge of the principles of the interviewing process and basic approaches to counseling pupils and parents. This should include behavior modification and guidance techniques. Opportunity for such counseling requires support from school administrators to provide basic needs, such as privacy and time for contact - both in school and away from school.

The adolescent students present a multitude of health concerns and many times they bring these concerns to the school nurse, rather than to their parents or family doctor. The recommendations and/or referrals she makes may strongly influence the students' future health.

In counseling with the parents or guardians, the school nurse needs to inform them of resources available for health care of their students and help them to use those resources to the best advantage. Home visits may be indicated, and should be part of the school health services. The home visit is indicated when: a student's complex health problem needs to be discussed with the parent; the parent is unable to come to school or has no telephone; direct family contact needs to be made; there seems to be multiple health problems and the family is unknown to the school nurse or faculty. (See Exhibit XIV for "Needs and Characteristics of School-Age Youth.")

6. Handicapped or Chronically Ill Children

Every school district is likely to have a number of students in its student body who suffer from handicapping conditions, or chronic illness. Most of the time these students can function in a general school program, if the school personnel are aware of their health problems and special needs.

It is recommended that:

a. Any student with a known or suspected diagnosis of a handicapping condition or chronic illness be referred to the school nurse. Parents and teachers are both responsible for reporting. At this time the school nurse should obtain enough medical information to determine the needs and potential of the student.

b. The school nurse talks with the student to discuss his concerns and needs. Together they make a plan for his adaptive school health needs.

c. The school nurse interprets the student's special problem to school personnel and participates in planning the instructional program.

d. The school nurse observes the student at intervals throughout the school year as needs indicate.

e. The student is instructed in self care by the school nurse if such assistance can be beneficial.

f. A confidential report of the student's health problem be made available to the teacher. The faculty should be made aware of the existence of the problem for purpose of emergency care. Inservice should be held with teachers as necessary to instruct them on types of emergency care that might be needed; e.g., what to do during an epileptic seizure, how to recognize a diabetic in insulin reaction or insulin shock, or signs of diabetic coma.

g. The school should follow the doctor's request for adaptive health care on limited activities for the pupil. Requests for limited activity should come as a written request from the doctor. (See Exhibit XVII for a sample form.)

h. The school nurse assists in coordinating service by acting as liaison with home health care agency, student, and school.

7. Communicable Disease Control (incl. Nuisance Disease)

In the field of communicable disease control, nurses, teachers, principals and other school personnel need to combine their efforts. The school nurse should keep up with current communicable disease regulations and see to it that the person in the schools responsible for exclusions and readmissions on the days the nurse is not in the school is also informed of current regulations. Students suspected or demonstrated to have a communicable disease are to be excluded from and readmitted to school according to State of Colorado Communicable Disease Control Laws and Regulations.

The school nurse needs to help the teachers develop their skills in observing symptoms which might indicate the onset of an acute communicable disease. The flip chart Communicable Disease Summary for Teachers printed by the Colorado Department of Health should be posted in a conspicuous area in every school. This flip chart lists "What to look for" in recognizing signs and symptoms of the listed diseases. "Prevention" and "Regulations" are also listed. For additional information or for disease problems not covered in this flip chart, contact your local health department or the Colorado Department of Health, Communicable Disease Control Section.

The question of closing the school during an epidemic often creates confusion and misunderstanding among parents and the general public. Your local health department or the Colorado Department of Health should be contacted for their recommendations if a concern of this type arises.

It is the school's responsibility according to the State of Colorado Communicable Disease Control Laws and Regulations to report within 24 hours to the local health department or State Department of Health the known or suspected diagnosis of the following diseases: (include name, address, age, sex, race, date of onset)

a. Diphtheria
b. Dog or other animal bites
c. Encephalitis (acute)
d. Poliomyelitis
e. Public gathering outbreaks (e.g. food poisoning)
f. Smallpox
g. Other diseases are also listed, but are not included here as they are not likely to be seen in the school.[6]

The following diseases shall also be reported by telephone or in writing, but there is no need to include the name, address, etc. as required for the above list. Only the number of cases needs to be reported for the following diseases:

a. Colorado tick fever
b. Rubella
c. Hepatitis
d. Influenza
e. Measles*
f. Mumps
g. Pertussis (whooping cough)
h. Rheumatic fever
i. Ring worm
j. Rocky Mountain spotted fever
k. Scabies
l. Streptococcal infection (strep throat, scarlet fever, scarletina)
m. Tuberculosis
n. Other diseases are also listed but are not included here as they are not likely to be seen in the school.[7]

(Exhibit XVIII is a copy of a letter to Dr. Vernon, Colorado Department of Health, stating the school responsibility in reporting communicable diseases.)

In 1977, a Quarantine Procedure was utilized in Colorado schools where a confirmed case of measles was reported. Since measles is highly contagious among unimmunized susceptible children, and may be responsible for serious complications, this Quarantine Procedure will probably continue to be used. Exhibit XIV is a copy of the Quarantine Order sent to the school. Exhibit XV is a copy of the Suggested Quarantine Procedure.

*At the present time measles shall be reported within 24 hours to the local health department or State Department of Health.

8. Mental Health in the Schools

by Dolores Leone, Mental Health Nursing Consultant

Mental health is the single most important asset a child can possess. Those qualities that distinguish one personality from another are often emotional qualities. They are the work of a complex system acting upon experience, reacting, adapting, storing, and integrating in a continuous effort to maintain a balance between inner needs and outer demands. Furthermore, physical and mental health is reflected in better physical health and vice-versa. We should not err by regarding "happiness" as the only criterion for mental health. Mental Health must also include the ability of the child to utilize fully his intellectual capacity to meet his needs. Mental health must also include a solid and integrated value system. A mentally healthy child has a positive self image, a sense of identity, a true perception of reality, and the ability to problem solve to meet the requirements of the situation. These children are happy, spontaneous, and productive. They establish appropriate relationships, with authority figures (parents, teachers, etc.) and peers, and are able to grow in knowledge and skill.

Although the primary responsibility for nurturing and socializing the child rests with the family, the school plays a major role in this task. Personality development is far from completed at five or six. When the child enters school new important influences enter into shaping his personality. The child spends the greater portion of his waking hours within the school setting and the daily activities in the classroom can greatly influence the process of socialization and maturation.

The school has the expressed function of teaching the child the knowledge and skills he will require in order to function as a reasonable, self-sufficient adult in society. It is a major socializing agency taking over from the family and implementing the family functions. One difference, however, is that the child is faced now with having his status determined by his achievements. He is confronted by significant adults who relate to him very differently from his parents. He becomes a part of a group of student peers and will learn to identify with them and to measure himself against them. He must begin to learn ways of living and relating himself as a member of society with its ideals and value systems. He must learn to become less dependent on his parents and their values, and to learn how others evaluate his capacities. In this process he moves toward forming a self-concept on which his own evaluation of himself and his future potentialities will rest.

Recognizing and accepting the importance of school influences on childhood development may seem like an awesome responsibility, but much can be done to ensure that the school is a positive influence in the emotional development of its children.

a. The Teacher

The personality of the teacher can have a very positive influence on children. Teachers who like children and like what they are doing will be attractive to children and help them to feel accepted and comfortable in the classroom. Teachers who take an interest in the background and personality of each child assist children to become individuals and will accept individual differences. A teacher who is personally consistent and self-confident will win the confidence and trust of children and will encourage children to take responsibility and contribute to school life.

On the other hand, teachers who are nervous, insecure, moody, and are not happy with teaching may foster negative behaviors in children or accentuate behavior problems already present.

b. The Classroom Environment

1) Physical Setting. The classroom environment should be cheery, with comfortable seating, heating and lighting, and ventilation. It should be orderly, attractive, and simple. This kind of environment will encourage self-control and cooperation from students, and offer a setting conducive to study.

2) Emotional Setting. The school personnel have the responsibility of providing an emotional climate in which each child feels accepted and is given the opportunity for maximum participation within the limits of physical and mental ability. Each child requires freedom to make decisions and to take responsibility. Each child has his own individual strengths, but every child has the right to experience some success in his school life.

c. The Peer Group

Each child has a need to feel a sense of belonging; the assurance that he is accepted and an integral part of the group. This can be enhanced by positive group experiences in the classroom and playground settings. Also the child needs to be assisted to develop a sense of responsibility; a willingness to live up to expectations. A child needs to be trustworthy in the sense of being reliable rather than simply honest. Lastly, the child needs to experience leadership. It is now, in finding his place among peers, that he begins to assume his place in society. He must learn that he can lead, that he can support a leader, or simply be a follower. The child needs experience in all these roles. In finding his place among peers and through being evaluated by adults, the child develops a more adequate evaluation of himself. He learns to see himself as others see him. Let us hope that the school is not responsible for the child seeing himself as a failure.

d. Communication: Evaluation

Teachers will understand children better if they know the home and family situation. Likewise, parents will be more interested in school life if they know the teacher and understand the school programs. Teachers should encourage parent involvement in the school and likewise teachers should involve themselves in the life of the community.

Children have the right to be judged fairly and objectively. Teachers should utilize a variety of means for evaluating the individual strengths and weaknesses of students academically, physically, and emotionally. Children are usually evaluated in comparison to others in the class, but more importantly, they need to be evaluated based on their own abilities and the progress they are making. It is important to repeat here that all children need to experience success and to receive rewards at one time or another.

e. Emotional Problems

Most children will generally adjust to school conditions without difficulty, although some may exhibit behavioral problems for short periods of time. In evaluating children, special consideration may need to be given to neglected, overprivileged or underprivileged children. In addition, the physical state of the child should be evaluated; for example, a chil[illegible]o is not being fed properly may appear listless and apathet[illegible] It is important to examine the child's environment and the stability in the home. Often house moves, divorces, job losses, death, etc. can substantially affect a child's functioning. It is important to keep in close communication with parents when a problem is identified. Some examples of problems that require further evaluation and intervention are:

1) Any severe and prolonged change in usual behavior.

2) Excessive withdrawal and regressive behavior.

3) Repeated aggressive, anti-social, or destructive behaviors.

4) Continual sexual or self-stimulatory behavior, i.e., masturbation, rocking, banging, etc.

5) Excessive anxiety, guilt, or fear-ridden attitude.

6) Continued enuresis and soiling.

7) Excessive dependency.

8) Inability to form or maintain interpersonal relationships.

9) Difficulty with authority - unable to accept direction or criticism.

10) Continuing somatic complaints with no physical basis.

Intervention begins with an interest on the part of the school personnel and a keen desire to understand and help the child having problems. Techniques for assisting the child include:

1) Analyzing conditions which may be at the root of the child's behavior such as the classroom environment, the teacher's attitude toward the child, other children's reactions to the child, and conditions in the child's home.

2) Call together the school resource people for a staff conference on the child with each discipline making their own contribution in evaluating the child. Be sure to include the teacher, school nurse, social worker or psychologist and any other available professional with an interest in the child. As much testing should be employed as will contribute to understanding the problems.

3) If it is found that the problems relate to something in the school environment, a plan of intervention should be agreed upon by the team and consistently applied with the knowledge and consent of the parents.

4) If the problems are complex, serious, and demand professional intervention on a prolonged basis, the family should be notified and counseled as to the availability of public and private resources for the treatment of children.

5) Whenever possible, the child should remain in school with added support from the teacher, nurse, social worker, or other helping personnel.

6) If the child must leave the school, if at all possible, efforts should be directed toward maintaining communication between the school and the treatment center, in order to assist school personnel in understanding treatment goals.

7) When the child returns to the school setting, efforts should be directed toward making the reentry as natural and untraumatic as is possible.

9. Health Office Management

The school health office is an important factor in the health service program. The school nurse needs a place to work which provides an atmosphere conducive to positive attitudes toward individual decision making about health matters. The physical environment should be clean, attractive and comfortable. It should provide privacy for counseling, holding conferences, or conducting health assessments.

No new school of any size should be constructed without a specifically designed health service unit. A health service unit should be well-lighted, well-ventilated, and placed in a quiet part of the building, as far away as possible from music rooms, lunch rooms, band practice, gymnasiums, flushing toilets, and noisy playgrounds, but easily accessible to and from the central office. Items to consider in planning a health office are:

a. Room(s) which provides privacy.
b. Convenient restroom facilities with hot and cold running water.
c. Cots with washable surface and/or disposable covers. One cot/400 students.
d. Room or area for emergency use in providing care for students who are ill, injured, infested with vermin, or suspected of having a contagious disease.
e. Telephone which can be used for making calls concerning confidential health matters.
f. Space long enough so that visual acuity checks are possible.
g. Desk with sufficient drawer space, and files and locked cupboards as needed for health records and supplies.
h. Room(s) situated so that access by litter or wheelchair is feasible.
i. Child-size furniture for the elementary school(s) health office.
j. Availability of a bulletin board for displays on health-related topics.

This health service unit may be more elaborate in large schools, but every school nurse should have adequate working area to carry out her duties.

When the school nurse is in a school part time, a visit schedule should be planned by the nurse and the school administrator. Once the schedule is agreed upon, it should be posted in the school with the secretary, and if the scheduled visit cannot be kept, the nurse should notify the school where she can be reached.

The school nurse should have secretarial time available to her from the office secretaries or clerical staff. Much of the health record keeping can be done by a school office personnel. This service should be arranged by the school nurse and the school administrator.

Many nurses have asked for an annual events calendar, listing dates for health-related topics or topics for bulletin boards or health education. This calendar will be found as Exhibit XXIV, as the last exhibit in Section I of this manual.

School health volunteers, health aides, and student aides are available to school nurses in many parts of Colorado. The school nurse should be responsible for coordinating and directing their services. This will be discussed in Chapter VI.

10. Health Education

In health education the school nurse plays an important role as a consultant and resource person. Health education is important to develop and provide learning experiences which will foster positive attitudes and behavior toward good health practices.

The school nurse cannot be responsible for teaching all the health education in a school district. She does have some expertise and may feel more comfortable teaching some subjects, but a total school health education program needs to be taught by the teachers and/or health educators. School nurses in Colorado are too few in number to provide a comprehensive health education program as well as provide health services to students.

Responsibilities of the school nurse in health education in the school are focused on participation in the program's formulation and development through:

a. assisting teachers to be more aware of health practices and problems, and to learn more about the maintenance of health;

b. assisting the teachers, as they work with the pupils in classroom activities to acquire the knowledge necessary for the building of healthful practices - an example: making available current authoritative health literature, visual aids, etc.;

c. assisting the teachers to provide for the student's integration of health knowledge into other learning activities, an example: basic nutritional knowledge woven into cultural patterns of family living;

d. assisting the teacher to encourage pupil self-direction in the practice of health habits - an example: the washing of hands - why? the care of minor first aid problems - why? and how?

e. providing for the availability of other types of health information materials - an example: bulletin board displays in health office and library materials in school and community resources.

Health Education will be discussed in detail in Section II of this manual by the Health Education Consultant from the Colorado Department of Education.

11. Healthful School Environment

The area of healthful school environment should be closely related to the other two areas of the school health programs--school health services and health instruction. The contributions of any one of the three aspects of the school health program strengthens the others.

The school nurse's concern for pupils extends to their physical environment. The nurse should be aware of minimum standards and should bring to the principal's attention any school building or playground conditions that need to be corrected.

Section III of this manual contains the Rules and Regulations for School Environment. The nurse's role will be discussed in that section.

Initiating Activities for a New School Nurse
"How to Begin"

How does a new nurse get started where there are no nurse supervisors or local plans for orientation? First of all, the administrator should explain the school district's philosophy of the school health program and interpret to the new school nurse her part in this program. Next the school nurse should become acquainted with any existing school health policies or procedures, and the school nurse job description. From there the school nurse should become familiar with the school environment. The week before school starts, when there are no students present, the school nurse should:

1. Meet the principals and the office staff.
2. Locate the school health office. Find out what clinic space and supplies are available. What is needed? How are the supplies ordered?
3. Locate the health records. Check on what type of health information is available. How confidential is it? Who records the health information? How up-to-date are the health records?
4. Obtain from the administrative office the information needed to plan a schedule, taking into consideration the number of schools, the number of pupils and the number of grades in each school.
5. Meet the faculty, describe the nurse's role and how students are referred to the nurse. Give them a copy of the school nurse's schedule.
6. Get acquainted with the cafeteria manager and workers, the bus drivers' supervisor, and the school custodian. Try to find what health problems or health hazards are present and how assistance in solving these problems may be rendered.
7. Become acquainted with community contacts. What community service clubs are there? Where to send students for emergency care? What services are available from the local or county health department? Who is available for crisis?
8. Become acquainted with the type of statistical data to be collected on the school nurse's activities for accountability of the school health program.

After becoming familiar with this necessary background information, the nurse should plan a tentative schedule of programs, including previously determined goals and objectives. The new school nurse should continue the programs in operation according to accepted policies until desirable changes can be made.

The school nursing responsibilities will vary according to the depth of the school health program in the school district. In rural Colorado, where the school nurse is also the public health nurse and the school program has to fit into the priorities of a total public health program, there may be a very limited service available within the schools.

However, there should be standards for that minimal school health program. The recommendations for such a program are:

1. Case finding

    - Review of school health records
    - Vision screening
    - Hearing screening
    - Health information obtained on all students new to the school system.

2. Follow-up on identified health problems

    - Notify student, parents and school personnel of vision and hearing screening failures, and record all students' screenings results on their individual school health records. (The secretary or teacher may do the recording.)

    - Discuss with parents and school personnel any health problems identified by reviewing school health records or from health information sheets. Make necessary referrals for care.

    - Make necessary recommendations for modification in individual educational programs when indicated.

3. Consultation to schools

    - Assess and evaluate health and developmental status of those pupils referred for specific health concerns, or those pupils being staffed into a special educational setting. Provide appropriate written feed-back to referral source following the assessment.

    - Serve as health consultant to school personnel in health education instruction.

    - Serve as liaison between parent, school, and community in health matters.

The following suggested monthly activities are for an expanded school health program, but will need to be adapted to the individual school district and its needs. Some of the activities listed can be done by clerical staff or health aides; however, it is the school nurse's responsibility to see that the activities are done.

FIRST SCHOOL MONTH - SEPTEMBER

1. Visit the classrooms, meet the students, and tell them where the health office is located.

2. Check First Aid supplies and arrange first aid cupboard.

3. Set up vision and hearing screening schedule for the year in schools and obtain principals' approval. The use of volunteer aides can help greatly in these time consuming checks.

4. Check health records and health problem lists for students who have physical defects. Notify teachers of students that need adjustments in a classroom such as hearing, vision, etc. Notify teachers of students with chronic health problems, and explain limits and potential problems or emergencies.

5. Bring the health record file up to date as soon as pupil placement is established.

6. Obtain class lists of all students attending school according to grade level.

7. Set a conference with principal and assistant principal and discuss plans and organization of health program for coming year.

8. Attend faculty meetings at assigned schools and discuss the health programs with teachers. Describe procedure used to refer students to nurse.

9. Attend school nurse staff meeting. If the district is small, these may be regional school nurse meetings instead of district meetings.

10. Confer with counselors and/or assistant principal with reference to students who are physically unable to take physical education. Students who were exempt from P.E. at end of previous year should be rechecked.

11. List all students who are to receive medications in school. See that the physician's letter is on file and medication is present in correctly labeled container.

12. Be aware of classroom lighting, seating, and ventilation (environmental sanitation) throughout the school year. Report to principal any negative or inadequate findings.

13. Begin weight and measurement program. Develop a cooperative plan with P.E. or other teachers to have this done and effectively screen out those who merit counseling on growth and diet.

14. Be aware of causes of absenteeism among students for the entire year. Report any unusual incidents or outbreaks of communicable disease to principal and other persons as requested.

15. Check School Emergency Contact cards for all students. If they have not been turned in, send another request with student.

16. Administer tuberculin tests to all new employees. Continue this practice throughout the school year as new employees report for duty. (This is to be done only if it is a policy in the school district.)

17. Check Immunization Record of new students in elementary schools. Use suggested tabulation form.

18. Follow-up on Preschool Kindergarten Health Screening Program. Check the number of medical examinations.

19. Send out Standard School Medical Examination Record forms for all new students.

20. Take part in student staffings throughout the school year.

21. Make appointments to begin fall teacher-nurse conferences of children's health status.

SECOND MONTH - OCTOBER

1. Monthly report for September due first week of this month. Submit to coordinator of school health program and/or principal.

2. Begin individual counseling with students already identified or known to have specific health problems, such as weight, acne, cardiac, and other conditions.

3. Counsel with students that have been referred for further follow-up examination during summer months.

4. Continue vision and hearing screening as scheduled.

5. Continue with evaluation of health records and request for health information and immunization records on new students.

6. Obtain from secretary complete lists of all students attending school according to grade level.

7. Plan participation in a faculty meeting. Discuss teacher referrals (demonstrate concrete examples of the result of referrals), and total health program.

THIRD MONTH - NOVEMBER

1. Submit monthly report for October during first week of month.

2. Continue with vision and hearing screening program, rechecks and refer failures.

3. Record health information received on individual health record.

4. Send periodic reminder to teachers regarding obvious or observable health conditions.

5. Send Immunization "Certification Summary" to Colorado Department of Health by November 15.

6. Send Immunization "List of Noncomplying Students" to Colorado Department of Health by November 15.

7. Continue counseling with students throughout the school year.

FOURTH MONTH - DECEMBER

1. Submit monthly report for November during first week of month.

2. Check all new students that have entered school since September. Request health information if not contained in transfer of records and make health record. Check medical examinations of students new to the district. Check immunization records of new students in elementary schools.

3. Continue to recheck all students that did not pass the initial vision and hearing tests. Keep tally on screening programs for students who did not pass second vision and hearing tests. Check on referrals made for further evaluation by family doctor.

4. Bring health records up to date.

5. Be aware of causes of absenteeism among students. Report any unusual situation or outbreak of illness to principal's office at any time throughout the year.

6. Submit monthly report for December BEFORE vacation.

FIFTH MONTH - JANUARY

1. Be alert to evidence of communicable diseases. Report any outbreak to principal's office and as required to local health authorities.

2. Be aware of causes of absenteeism among students (see 5 above).

3. Record vision and hearing tests results on health records.

4. Dental Health Week is February. Dental education should be done at this time. Prepare dental screening list and dental orientation forms.

SIX MONTH - FEBRUARY

1. Submit monthly report for January during first week of month.

2. Check referrals made for vision and hearing or any other evaluation.

3. Continue with health records and health information.

4. Send periodic reminder to teachers regarding obvious and observable health conditions among students; especially at the secondary level at the start of the new semester.

5. Dental screening program in elementary and middle schools.

6. Begin vision and hearing for screening new students who were missed in fall screening programs.

7. Follow-up on employee T.B. testing.

8. Plan for spring preschool health screening program for Kindergarten registration.

SEVENTH MONTH - MARCH

1. Submit monthly report for February.

2. Follow-up on referrals. Request parent conference if necessary, or make home visits.

3. Follow-up on employee tuberculin tests, etc.

4. Scoliosis screening program in 5th, 6th, and 7th grades.

5. Send Immunization duplicate copy of the list of noncompliers, indicating date of compliance, or date withdrawn, for each listed child, to Colorado Department of Health by April 1.

EIGHTH MONTH - APRIL

1. Submit monthly report for March.

2. Follow-up on referrals from Scoliosis Screening Programs.

3. Check all students that have entered school since beginning of the semester. Request health information if needed and record on health record.

4. Review 6th and 9th grade health records. List students with known health problems to be sent to junior high school and senior high school nurse for the beginning of the coming school year.

5. Make appointments to begin spring teacher-nurse conferences of children's health status and recommendations to be passed on to next year's teacher.

NINTH MONTH - MAY

1. Submit monthly report for April during first week of month.

2. Carefully check correction of defects and follow-up on all referrals where no action has been taken.

3. Conduct preschool health screening program in conjunction with Kindergarten registration.

4. Send health records and health problem lists to junior high schools and high schools.

5. Prepare nurse's room for close of school.

6. Send medical examination forms home for those students requested to have an exam prior to the next fall.

7. Submit monthly report for May before school is out.

8. Be sure that each cumulative health record is current.

9. Submit health room supply order for next year.

Function and Activities of School Nurse Practitioner*

Submitted by Judy Igoe
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In cooperation and consultation with other health professionals, educators, and school personnel (e.g., physicians and other primary care providers, psychologists, social workers, nutritionists, mental health workers, dentists, and dental hygienists), school nurse practitioners assume initiative and responsibility for providing a wide variety of health care functions and activities.

School nurse practitioners who have had adequate formal educational preparation can:

ASSESS HEALTH STATUS

--Obtain and evaluate a discriminative, accurate, and relevant health history.
--Evaluate physical, emotional, psychological, perceptual, social, cognitive and intellectual development and recognize normal variations and abnormalities.
--Participate in the identification and evaluation of physical disease, learning disorders, perceptual-cognitive difficulties, emotional disturbances, and behavior problems.
--Recognize and understand how cultural life style, family dynamics, and economic, ethnic, and environmental factors affect health.
--Understand the nutritional needs of children.
--Perform an accurate and appropriate physical examination, including a neurological examination that incorporates screening for perceptual difficulties.
--Carry out and assess appropriate developmental and psychological screening tests through a variety of observational, interviewing, and testing methods.
--Perform and assess a variety of preventive, screening, and diagnostic procedures (e.g., throat and urine culture, hematocrit determination, urinalysis, tuberculin test, sickle cell anemia screening test, pregnancy tests).

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*Adapted from: 1)Silver, H.K., Igoe, J.B., and McAtee, P.R.: The School Nurse Practitioner: Providing Improved Health Care to Children. Pediatrics, 58:580, 1976; and 2) Guidelines on Educational Preparation of Competencies of the School Nurse Practitioner. A Joint Statement of the American Nurses' Association, The American School Health Association, and the Department of School Nurses/National Education Association, June, 1975.

PROVIDE HEALTH CARE

--Manage a variety of health problems including common pediatric illnesses, accidents, and other disorders.

--Provide extensive well-child care with emphasis on preventive health care practices.

--Employ appropriate health services for emergencies.

--Distribute prescribed medications and supervise treatment regimens in the school.

--Provide follow-up care as needed for children with health, learning, and emotional problems.

--Arrange and participate in planning for the health needs of children including appropriate disease and accident prevention and immunization programs.

--Recognize the complications of illness and injury.

INTEGRATE CARE

--Participate in formulating and implementing plans involving family, school, and community so as to enhance the quality and continuity of health care for children and diminish fragmentation and duplication of services.

--Arrange for appropriate referrals for children with health problems which require further evaluation and care by physicians and others.

--Participate in the formulation, implementation, and coordination of standards, policies, and procedures for school health services.

--Assist parents in identifying and utilizing appropriate private and community resources for health care.

--Serve as health consultants to administrators, teachers, other school personnel, and the community.

--Make home visits when indicated for effective management of health problems.

FOSTER HEALTH EDUCATION

--Participate in the education of teachers and other school personnel in the prevention of disease and the maintenance of health.

--Provide relevant health instruction, counseling, and guidance to students, parents, teachers, and others concerning a variety of acute and chronic health problems including common illnesses, accidents, dental health, nutrition, developmental crises, family planning (for teenagers), drug, alcohol, and cigarette abuse and prevention, the dangers of environmental hazards, the impact of health problems on learning and school performance, and assume responsibility for appropriate intervention, management, and/or referral.

--Apply methods designed to increase children's motivation to participate in and assume responsibility for their own health care.

--Assist parents to learn about health problems and the need to assume greater responsibility for the health care maintenance of their children.

Professional Growth and Inservice

School nurses should have a definite interest in and responsibility for professional growth. Nurses who identify themselves by affiliation with and active participation in national and state nursing organizations will profit from such association with others in the profession.

School nurses can increase their knowledge by:

1. Attending professional growth program sponsored by local school district.
2. Attending regional or state workshops sponsored by professional organization or the Colorado Department of Health, or Colorado Department of Education.
3. Attending formal education or continuing education courses offered by local universities and colleges.
4. Doing independent reading in their professional area.

School nurses should have "professional released time" to attend relevant workshops that occur throughout the school year. Some school districts allow the school nurse 6 to 10 days of such time during one school year. This is an item that ought to be negotiated with the school district administration each year.

Certification of School Nurses

Certification of school nurses is not mandatory in all areas of the state of Colorado. The Colorado Board of Nursing is investigating the possibility of making certification mandatory for all nurses for relicensure in the not too distant future.

The Colorado Department of Education does offer a Type E - School Nurse certification. Some school districts do require their nurses to have this type of certification. The requirements for initial certification are:

> "School nurse, K-12: To be endorsed school nurse, an applicant shall have satisfied the following requirements:
>
> 1. Hold a bachelor's or higher degree, preferably in nursing, from an accepted institution of higher education.
> 2. Have completed studies designed to develop knowledge and skills in the following areas:
>   - The organization and administration of community health/ public health nursing services.
>   - Health concerns of school youth.

- The conduct of basic health examinations.
- Mental health of children and teachers.
- Family case work, health, social problems.
- Community agencies.
- Legal rights and due process of students, parents, teachers, administrators, and school boards.

3. Have completed a supervised practicum in a community health/public health setting."

This certificate "may be renewed upon submitting an application for renewal, payment of the statutory fee, and evidence of completion of a professional growth plan consisting of six or more semester hours of renewed credit earned within the five-year period prior to the date of application."

For more information and appropriate form for either initial certification or recertification, contact your local school district administration, or the Colorado Department of Education, Certification Division.

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4. School Health Services Handbook for Administrators and Health Personnel, prepared by Colorado Advisory Committee on School Health, 1967, p. 19.

5. Platform and Policy Statements, Department of School Nurses, National Education Association, Washington D.C., June 1972.

6. Communicable Disease Control - Laws and Regulations, adopted by Colorado State Board of Health, 1968, p. 21.

7. Communicable Disease Control - Laws and Regulations, adopted by Colorado State Board of Health, 1968, p. 22.

EXHIBIT XII

MEDICAL HISTORY AND PHYSICAL EXAMINATION FOR SCHOOL HEALTH PROGRAM

Name ______________________ Date of Birth ______________

Parents or Guardians ______________________________

Address ______________________ School ______________

PARENT: Has your child had any of the following diseases? When?

Rubeola (10-day Measles)	
Rubella (3-day Measles)	
Chicken Pox	
Mumps	
Whooping Cough	

What known allergies does your child have? ______________

What serious illness or injuries has your child had? ______________

____

What physical limitations does your child have? ______________

What medications does your child take regularly? __________ When? __________

PHYSICIAN OR PARENT: Record of known immunizations and tuberdulin test.

	Date	Boosters
Diphtheria-Pertussis-Tetanus (D-P-T)		
Diphtheria-Tetanus (D-T)		
Oral Polio		
Smallpox		
Rubeola (10-day Measles)		
Rubella (3-day Measles)		
Mumps		
Tuberculin Test		

PARENT COMMENTS: ______________ SCHOOL NURSE COMMENTS: ______________

______________ ______________

______________ ______________

Parent Signature Nurse Signature

Physician or other examiner: Please complete the following:

Is there any history of birth injury, head injury, abnormal growth or development, or congenital defects in this child or family?

Height______ Weight______ Pulse __________ Blood Pressure ____________

	Normal	Abnormal	Explanation
General Appearance			
Skin and Hair			
Eyes			
Ears			
Nose and Sinuses			
Teeth			
Lymph Nodes			
Tonsils and Throat			
Neck and Thyroid			
Chest and Lungs			
Heart			
Abdomen			
Genitalia			
Extremeties			
Spine			
Neurological			

URINALYSIS: Specific Gravity______ Alb_____ Sugar_____ Micro. if indicated ____________

BLOOD EXAMINATION: Hematocrit____________ RBC or WBC if indicated ________________

Recommendations to the School Nurse, School Psychologist, or Administrator:

Check here if you would like school personnel to call you to discuss any problem. ______

RECOMMENDATIONS REGARDING PHYSICAL ACTIVITY:

Approved for regular physical education program including swimming Yes___ No ___

Approved for competitive sports not crossed out below:

Baseball Basketball Cross Country Field Hockey Football
Golf Gymnastics Soccer Softball Swimming
Tennis Track Wrestling Volleyball

Date ______________________

Signature of Physician ________________________
Phone ____________________________

EXHIBIT XIII

DISQUALIFYING CONDITIONS FOR CONTACT SPORTS — FOOTBALL, WRESTLING, HOCKEY, BOXING, BASKETBALL, BASEBALL, SOCCER AND LACROSS

	Absolute Contraindications	*Relative Contraindications*
1. Neurological	1. Concussion with loss of consciousness — out of the game. 2. Two concussions — out for the season.	1. Epilepsy, if well controlled (no seizure for one year). 2. A grandmal seizure can follow a head injury without other evidence of epilepsy. This type of seizure should fall into the same category as concussion.
2. Eye	1. Absence of one eye or amblyopia of one eye of 20/200 (corrected). 2. Retinal detachment (repaired) or (unrepaired). 3. Congenital glaucoma.	1. Active eye infection.
3. Respiratory	1. Any active lung infection, including tuberculosis.	1. Bronchial asthma (may participate to tolerance).
4. Cardiovascular	1. Cardiac enlargement from any cause. 2. Severe mitral stenosis. 3. Aortic stenosis. 4. Cyanotic heart disease. 5. Active myocarditis. 6. Symptomatic pulmonary hypertension.	1. Resting BP over 140 systolic and 90 diastolic should be studied before allowing participation in athletics.
5. Endocrine		1. Diabetes is a contraindication only if there is poor control and supervision.
6. Abdomen	1. Undescended testes over the pubic ramus. 2. Any enlarged major abdominal organ (spleen, liver, kidney).	1. Inguinal hernia.
7. G-U System	1. One kidney missing or seriously damaged. 2. Active kidney infection.	1. One testicle missing.
8. Musculoskeletal	1. Navicular fracture until healing is complete. 2. Spondylolisthesis and spondylolysis. 3. Hip disease (a) Legg Perthes (b) Slipped epiphysis (c) Septic hip 4. Active epiphysitis of the spine.	1. Instability of the knees. 2. Recurrent dislocation of the shoulder. 3. Osgood Schlatter's disease, where there is pain on movement. 4. Tendency to develop myositis ossificans. 5. Amputees—See AMA recommendation.
9. Hematological	1. Blood coagulation defects.	
10. Skin		1. Active bacterial infection. 2. Active herpes simplex 3. Severe cystic acne.

EXHIBIT XIII (continued)

Disqualifying Conditions for Non-Contact Sports — Tennis, Golf, Swimming, Track, Gymnastics
Conditions listed under Contact Sports will apply, with the following exceptions:

	Absolute Contraindications	*Relative Contraindications*	*No Contraindications*
1. Neurological	1. In swimming and certain gymnastics, such as the rings and high bar, epilepsy, if there has been a seizure in the previous year.		1. Susceptibility to cerebr concussion.
2. Eye			1. One eye missing or amblyopic.
3. Abdomen		1. Enlarged abdominal organ.	1. Undescended testes ove the ramus.
4. Cardiovascular		1. Cardiac enlargement from any cause. 2. Severe mitral stenosis. 3. Aortic stenosis. 4. Cyanotic heart disease. 5. Active myocarditis. 6. Symptomatic pulmonary hypertension. 7. BP above 140/90.	
5. G-U System		1. One kidney missing.	1. Testicle missing.
6. Musculoskeletal		1. Navicular fracture.	
7. Hematological		1. Blood coagulation defects.	

(Taken from the guideline printed by the Colorado High School Activities Association.)

EXHIBIT XIV 1

GUIDE FOR TEACHERS REFERRAL TO NURSE

It is recommended that the following observations be referred to the school nurse:

1. Eyes
   a. Sties or crusted eye lids
   b. Inflamed eye lids
   c. Crossed eyes
   d. Repeated headaches
   e. Protruding eyes
   f. Watery eyes
   g. Rubbing eyes
   h. Excessive blinking
   i. Twitching of the lids
   j. Holding head to one side
   k. Complaints of blurry vision

2. Ears
   a. Discharge from ears
   b. Earache
   c. Failure to hear questions
   d. Picking at the ears
   e. Turning head to hear
   f. Talking in a monotone
   g. Attention
   h. Anxious expression
   i. Excessive noisiness of child
   j. Ringing in ears
   k. Dizziness

3. Nose and Throat
   a. Persistent mouth breathing
   b. Frequent sore throats
   c. Recurrent colds
   d. Chronic nasal discharge
   e. Frequent tonsillitis
   f. Nasal speech
   g. Frequent nose bleeding
   h. Chronic coughing

4. Skin and Scalp
   a. Unusual pallor of face
   b. Eruptions or rashes
   c. Habitual scratching of scalp or skin
   d. Nits on the hair
   e. State of uncleanliness
   f. Excessive redness of the face

5. Teeth and Mouth
    - a. State of uncleanliness
    - b. Gross caries
    - c. Irregular teeth
    - d. Stained teeth
    - e. Gum boils
    - f. Offensive breath
    - g. Mouth habits such as thumb sucking
    - h. Complaints of a toothache
    - i. Swollen jaw

6. General Condition and Appearance
    - a. State of underweight - very thin
    - b. Overweight - very obese
    - c. Does not appear well
    - d. Tires easily
    - e. Chronic fatigue
    - f. Nausea or vomiting
    - g. Faintness or dizziness
    - h. Chronic menstrual discomfort
    - i. Chronic absenteeism

7. Glands
    - a. Enlarged glands at side of neck
    - b. Enlarged thyroid

8. Growth
    - a. Failure to gain regularly over six-month period
    - b. Unexplained loss of weight
    - c. Unexplained rapid gain in weight
    - d. Complaints of "Growing Pains"

9. Heart
    - a. Excessive breathlessness
    - b. Tires easily
    - c. Bluish lips or fingernails
    - d. Excessive pallor

10. Posture and Musculature
    - a. Alignment of shoulders and hips
    - b. Peculiarity of gait
    - c. Obvious deformities of any type
    - d. Round shoulders
    - e. Muscular development
    - f. Coordination
    - g. Muscle tone
    - h. Use of feet in standing and walking

11. Behavior
    a. Over studious, docile, withdrawing
    b. Bullying, over aggressiveness and domineering
    c. Unhappy and depressed
    d. Over excitable, uncontrollable emotions
    e. Stuttering or other forms of speech difficulty
    f. Poor accomplishment in comparison with ability
    g. Lying (imaginative or defensive)
    h. Lack of appreciation of property rights (stealing)
    i. Abnormal sex behavior
    j. Antagonistic, negativistic, continually quarreling
    k. Excessive use of toilet
    l. Enuresis

12. Any Chronic Illness (known or suspected diagnosis)
    a. Asthma
    b. Diabetes
    c. Epilepsy
    d. Rheumatic Fever or Heart Disease
    e. Cystic Fibrosis
    f. Orthopedic Condition
    g. Severe hearing loss
    h. Unremedial visual loss or handicap
    i. Other special conditions

13. Students who lack medical care due to financial stress or religious views.

14. Known or suspected social, family, financial situations affecting the health of the student.

15. Prolonged absenteeism due to illness.

16. Homebound students.

17. Suspected or known pregnancies.

18. Children receiving medications for a prolonged time and for chronic conditions such as tranquilizers, antihistamines, insulin, anticonvulsants, etc.

19. Students new to the school district.

Taken from School Nurse Handbook printed by Pueblo School District #60, September, 1976.

EXHIBIT XV

Referrals to the School Nurse

School ______________________ Teacher ______________________ Room ______

Date	Child's Name	Reason for Referral	Nurse's Findings

EXHIBIT XVI

NEEDS AND CHARACTERISTICS OF SCHOOL-AGE YOUTH

A. Physical

B. Emotional

C. Social

D. Intellectual

The following tables were revised in format and reproduced with permission of W. B. Saunders Company, Philadelphia, Pennsylvania, 1965. The table appeared in The School Health Program by Alma Nemir.

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A. PHYSICAL NEEDS AND CHARACTERISTICS

PRESCHOOL - AGES 3-5

Characteristics

1. Rate of growth slows.
2. Disproportion in size of trunk to short arms, and legs, and trunk to head.
3. Still developing balance, falls easily.
4. Large muscle development.
5. Locomotor and manipulative play enjoyed.
6. Physically more stable in circulation, respiration, and body temperature.
7. Body functions and habits fairly well established.
8. Primary teeth erupted.
9. Restless, active.
10. Fatigue displayed by crossness, possibly heightened activity.
11. Visual acuity approaches normal.
12. Highly susceptible to communicable diseases.

Needs

1. To have wide variety of activities for use of large muscles - running, climbing, hanging.
2. To use equipment for developing muscle control - wagons, tricycles, hammer, nails, blocks, dolls, sand.
3. To develop independence (self-help) in toileting, washing, dressing, eating.
4. To have guidance in establishing habits of cleanliness, sleep, and rest.
5. To have health examinations and follow-up.
6. To have visual and auditory checks.
7. To have dental attention.

KINDERGARTEN - GRADE 3, AGES 5-8

Characteristics

1. Growth relatively slow.
2. Increase in large muscle coordination, beginning of development of small muscle control.
3. Bones growing.
4. Nose grows larger
5. Permanent teeth appearing or replacing primary teeth. Lower part of face more prominent.
6. Hungry at short intervals. May overeat and become fat.
7. Enjoys active play - climbing, jumping, running.
8. Susceptible to fatigue and limits himself.
9. Visual acuity reaches normal.
10. Susceptible to respiratory and communicable diseases.

Needs

1. Develop large muscle control through motor skills.
2. To have play space and materials.
3. To use instructional tools and equipment geared to stage of development.
4. To establish basic health habits - toileting, eating, covering nose and mouth with cough, etc.
5. To have snack time and opportunity to develop social graces.
6. To have plenty of sleep and rest, and exercise interspersed with rest.
7. To have health examinations and follow-up.
8. To have visual and auditory checks.
9. To have dental attention.

GRADES 4-6 - AGES 8-11

Characteristics

1. Growth slow and steady.
2. Girls begin to forge ahead of boys in height and weight.
3. Extremities begin to lengthen toward end of this period.
4. Muscle coordination improving.
5. Continued small muscle development.
6. Bones growing, vulnerable to injury.
7. Permanent dentition continues.
8. Malocclusion may be a problem.
9. Appetite good. Increasing interest in food.
10. Boundless energy, tires easily.
11. Visual acuity normal.
12. Menarche possible towards end of this period.

Needs

1. To develop and improve coordination of both large and small muscles.
2. To have plenty of activities and games which will develop body control, strength, endurance and skills - stunts, throwing, catching, running, "it," bicycles, skates.
3. To have careful supervision of games appropriate to strength and developmental needs - protective equipment.
4. To have competitive activity with children of comparable size.
5. To have sleep, rest, well-balanced meals.
6. To have health examinations and follow-up.
7. To have visual and auditory checks.
8. To have dental attention.

GRADES 7-9 - AGES 11-14

Characteristics

1. Accelerated, uneven growth.
2. Individual differences most prominent: girls continue rapid growth, are taller and heavier than boys in early period.
3. Muscular growth toward adult size begins toward end of period.
4. Variable coordination.
5. Bones growing, vulnerable to injury.
6. Dental caries common.
7. Permanent dentition - 28 teeth.
8. Malocclusion may be present.
9. Appetite ravenous but may be capricious.
10. Enjoys vigorous play.
11. Tires easily (especially girls).
12. Visual problems increase.
13. Variations in development of secondary sexual characteristics. Menarche.
14. Skin problems, voice changes, etc.
15. Reproductive organs growing.

Needs

1. To have adequate nourishment for growth spurt and daily energy.
2. To understand developmental changes of adolescence.
3. To recognize wide physical difference as normal.
4. To have good practice equipment in games.
5. To have physical activity interspersed with rest.
6. To have health examinations and follow-up.
7. To have visual and auditory checks.
8. To have dental attention.

GRADES 10-12 - AGES 14-18

Characteristics

1. Rapid growth nearing end of physical maturity by graduation time.
2. Increase in height of trunk, then widening of shoulder and pelvic girdles.
3. Gradual increase in adult muscular development.
4. Posture approaches adult stance.
5. Bone growth gradually reaches completion.
6. Dental caries common.
7. Malocclusion may be present.
8. Voracious appetite.
9. Develops food fads.
10. Vigorous play satisfying.
11. Still tires readily in early period.
12. Visual problems increase.
13. Approaches and completes adult maturation.

Needs

1. To have plenty of nutritious foods and establish good habits of food selection--to avoid food fads.
2. To understand body growth and development of own and opposite sex.
3. To accept individual differences without feeling inferior or superior, knowing that differences are desirable.
4. To have help in accepting or improving own stature, muscular development, complexion, visual defects, etc.
5. To have adequate rest.
6. To have health examinations and follow-up.
7. To have visual and auditory checks.
8. To have dental attention.

B. EMOTIONAL NEEDS AND CHARACTERISTICS

PRESCHOOL - AGES 3-5

Characteristics

1. Self-centered - just learning.
2. Wants to do things himself.
3. Resents interference with play or possessions.
4. May show off, yet shy of strangers.
5. Periods of negativism in effort to exert self-determination.
6. Few inhibitions, frank expression of emotion; may bite, scratch, fight, or cry to get what he wants.
7. Shows affection freely.
8. Accepts self as an individual.
9. Increasing individuality.
10. Strong attachment to mother.
11. Curious about sex organs.

Needs

1. To have adult support individual needs of acceptance and love.
2. To have affectionate personal interests of adults.
3. To accept authority.
4. To learn to identify with parents, siblings, and others.

KINDERGARTEN - GRADE 3 - AGES 5-8

Characteristics

1. Self-centered, desires immediate attention to his problem - wants to be first.
2. Sensitive at being left out.
3. Sensitive to ridicule, criticism or loss of prestige.
4. Easily aroused emotionally.
5. Can take responsibility but needs adult supervision.
6. Parent image strong; also identified with teacher.
7. Expresses likes and dislikes readily.
8. Questioning attitude about sex differences.

Needs

1. To have a consistent, cooperatively planned program of classroom control. Must have guidance.
2. To develop self-confidence.
3. To have some immediate desirable satisfaction.
4. To know limitations within which he can operate effectively.
5. To develop realistic expectations of self.

GRADES 4-6 - AGES 8-11

Characteristics

1. Seeks approval of peer group.
2. Desire to succeed.
3. Enthusiastic, noisy, imaginative, desire to explore.
4. Negativistic - early part of period.
5. Begins to accept responsibility for clothing and behavior.
6. Increasingly anxious about family and possible tragedy.
7. Increasing self-consciousness.
8. Sex hostility.
9. Becomes "mo[illegible]" but not too interested in details of sex.

Needs

1. To exercise self-control.
2. Talk out problems, receive reasonable explanations, to have questions answered.

GRADES 7-9 - AGES 11-14

Characteristics

1. Emotional instability - sudden and deep swings in mood.
2. Strong feelings of like and dislike, negative and positive attitudes.
3. Sensitive, self-critical, but cannot take criticism.
4. Over anxious about health - thinks he has a gruesome disease.
5. Overconcerned about physical and emotional changes.
6. Striving for independence from adults.
7. Hero worship.
8. Searching for sensational experience.
9. Self-conscious.
10. Shows growing restraint in expressing feelings.
11. Unique sense of humor.

Needs

1. To have privacy respected.
2. To exercise self-discipline.
3. To experience success, receive individual recognition.
4. To identify with a friendly adult - teacher, parent, older friend.
5. To be alone occasionally.
6. To feel the support, firm guidance, and assurance of an adult.
7. To differentiate between reality and fiction, fact and fiction.

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GRADES 10-12 - AGES 14-18

Characteristics

1. Intensely emotional, labile, volatile, gradually settles down.
2. Sensitive to economic and social status of family and self.
3. Sensitive to own inadequacies and incompetencies - may be expressed as antisocial or childish behavior.
4. Concerned about future.
5. Intensely loyal to an individual or group with whom he identifies.
6. Still striving for independence from parents and others, but often wants adult support.
7. Self-conscious.

Needs

1. To exercise self-control.
2. To be accepted, receive approval and recognition.
3. To understand one's self and others.
4. To have group acceptance and identification.

C. SOCIAL NEEDS AND CHARACTERISTICS

PRESCHOOL - AGES 3-5

Characteristics

1. Will cooperate in play but likes to be "bigger than."
2. Cooperative play and parallel play intermixed.
3. Begins to initiate play with several other children.
4. Beginning sense of ownership, but more willing to share.
5. Responsive to cultural pressures.
6. Boys and girls play together. Similar interests.

Needs

1. To have companionship and play with other children of same age.
2. To take turns and share - cooperative and loosely shared play with one, or at times, several children.
3. To enjoy active play.
4. To have help in gaining social skills.
5. To accept children who are "different."
6. To note sex differences and cultural roles of the sexes.

KINDERGARTEN-GRADE 3 - AGES 5-8

Characteristics

1. Lack of interest in personal grooming.
2. Engages in imitative play.
3. Friendly, frank, sometimes aggressive, "bossy," assertive.
4. Generally tolerant of race, economic status, etc.
5. Gradually more socially oriented and adjusted.
6. Boys and girls play together as sex equals, but aware of sex difference.

Needs

1. To have satisfactory peer relationships; to receive group approval.
2. To learn the importance of sharing, planning, working, and playing together - both boys and girls.
3. To have help in developing socially acceptable behavior.
4. To learn to assume some responsibility, to have opportunities to initiate activities, to lead.
5. To work independently and in groups.
6. To accept sex role.
7. To develop an appreciation of social values, such as honesty, sportsmanship, etc.

GRADES 4-6 - AGES 8-11

Characteristics

1. Learns to cooperate better. Group planning and group play, and abides by group decisions.
2. Interested in competitive activities and prestige.
3. Competition keen.
4. Begins to show qualities of leadership.
5. Developing interest in appearance.
6. Strong sense of fair play.
7. Belongs to a gang or secret club. Loyal to group.
8. Close friendships with members of own sex.
9. Separate play for boys and girls.

Needs

1. To be recognized and accepted by peer groups - receive social approval.
2. To have relationships with adults which give feelings of security and acceptance.
3. To assume responsibilities, have increased opportunities for independent actions and decisions.
4. To develop appreciation for others and their rights.
5. To learn to get along with others and accept those different from self.

GRADES 7-9 - AGES 11-14

Characteristics

1. Interested in competitive sports as participant and spectator.
2. Developing good sportsmanship.
3. Socially insecure.
4. Peer-conscious - very much so.
5. Desires freedom with security.
6. Argues against authority but wants it.
7. Sensitive to appearance, clothes, skin.
8. Imitative fads in clothing, speech, etc.
9. Wishes to conform to clearly defined pattern of good school cititenship.
10. Assumes responsibility for personal and group conduct.
11. Beginning to discriminate right from wrong.
12. Aware of opposite sex, chivalry, rivalry, teasing.
13. Separating into groups by sex - boys into large groups, girls into small groups - then gradually to mixed groups.

Needs

1. To see one's self as a socially accepted, important person.
2. To relate to members of the same and opposite sex.
3. To receive recognition from and acceptance by peers.
4. To work and play with different age groups.
5. To recognize the importance of leadership as well as being a follower.
6. To have congenial social settings.

GRADES 10-12 - AGES 14-18

Characteristics

1. More mature adjustments in social groups.
2. Sense of fair play in games.
3. Concerned about justice, moral code, right and wrong.
4. Responds well to group responsibility and group participation.
5. Regards possessions as evidence of social prestige.
6. Imitative fads.
7. Tends to challenge traditional customs, values, and procedures.
8. Tends to identify with an older, admired friend.
9. Wants to be accepted by gang, clique, or social group.
10. Interested in opposite sex; gradually, consciously or unconsciously, seeking a mate.

Needs

1. To feel adequate in associations with the opposite sex.
2. To have a wide variety of social activities and competencies, including social dancing.
3. To be increasingly independent.
4. To talk, to communicate freely with others on any topic.
5. To increase wholesome relationships with people of all ages, races, creeds, and cultures.
6. To receive fair and consistent treatment.
7. To have respect for authority.

D. INTELLECTUAL NEEDS AND CHARACTERISTICS

PRESCHOOL - AGES 3-5

Characteristics

1. Imaginative play.
2. Learns to distinguish between real and fantasy.
3. Beginning interest in stories, music, art work.
4. Laughter and nonverbal forms of communication are frequent.
5. Growing interest in world around him, what makes things "work."
6. Developing initiative and language communication.
7. Easily distracted.

Needs

1. To discover emotional satisfactions with companions of own age group.
2. To begin independence from parents yet maintain security of parental protection.
3. To have freedom to explore, try new ideas, extend environment, "to do," "to help."
4. To have first-hand experiences - to see, feel, touch, taste, smell.
5. To have explanations repeated while learning new concepts.
6. To have time and opportunity to explore.
7. To have answers to "why."
8. To be treated with patience and courtesy and listened to and talked to by accepting adults.

KINDERGARTEN-GRADE 3 - AGES 5-8

Characteristics

1. Varied intellectual growth and ability of children.
2. Interested in things that move, bright colors, dramatizations, rhythmics, making collections.
3. Interested in the present, not the future.
4. Learns best through active participation in concrete, meaningful situations.
5. Can abide by safety rules.
6. Wants to know "why."
7. Attention span short.

Needs

1. To receive encouragement, recognition, ample praise, patience, and adult support.
2. To express inner feelings, anxieties, and fears.
3. To feel secure, loved, wanted, accepted (at home and at school).
4. To be free from pressure to achieve beyond capabilities.
5. To experience frequent success and learn to accept failure when it occurs.
6. To have concrete learning experiences and direct participation.
7. To be in a rich, stable, challenging environment.
8. To have time to adjust to new experiences and new situations.
9. To learn to follow through to completion.
10. To develop a love for learning.
11. To learn without developing feelings of hostility.
12. To communicate effectively.

GRADES 4-6 - AGES 8-11

Characteristics

1. Likes to talk and express ideas.
2. High potential of learning - in science, adventure, the world.
3. Eager to acquire skills.
4. Wide range of interests. Curious, wants to experiment.
5. Goals are immediate.
6. Demands consistency.
7. Generally reliable about following instructions.
8. Attention span short.

Needs

1. To begin seriously to gain a realistic image of self and appreciate uniqueness of personality.
2. To be recognized for individual worth, to feel self-assurance and self-esteem.
3. To receive encouragement and affection, to be understood and appreciated.
4. To experiment, explore, solve problems, be challenged, use initiative, select, plan, evaluate.
5. To receive individual help in skill areas without harmful or undue pressure.
6. To have opportunities for creative self-expression.
7. To have a rich environment of materials and the opportunity to explore it.
8. To participate in concrete, real-life situations.
9. To be able to accept one's self with strengths and weaknesses.

GRADES 7-9 - AGES 11-14

Characteristics

1. Eager to learn. Curious alert, exploring.
2. Reads widely.
3. Wider range of abilities and interests.
4. Wants to succeed.
5. Wants precise assignments and meaningful experiences.
6. Skeptical, demands facts.
7. Unrealistic in passing judgment.
8. Overconfident in own information.
9. Increasing span of attention and concentration.

Needs

1. To express volatile emotions, grief, anger, disappointments, likes, dislikes.
2. To assume responsibility for own conduct.
3. To achieve more independence.
4. To feel secure, wanted, loved, trusted, adequate, capable.
5. To determine individual motives, goals, standards, and ideals.
6. To satisfy curiosity, desire to know, to experiment.
7. To express one's self orally, manually, and through activities such as dance, music, clubs, debate, etc.
8. To appreciate the value of work and products of work.
9. To know the satisfaction of achieving to the extent of one's ability.

GRADES 10-12 - AGES 14-18

Characteristics

1. Wider range of differences in mental abilities of students.
2. May tend to subordinate intellectual drives to social and emotional.
3. Is trying to establish a degree of independence - intellectually, socially, and economically.
4. Searching for ideals - developing a philosophy of life.
5. Planning future role.
6. Extending interest to world situation, citizenship, scientific progress.
7. Long periods of concentration possible.

Needs

1. To have relationships with adults who invite confidence and give moral support and security.
2. To achieve success.
3. To have a family solidarity as an escape from the confusion of the world.
4. To set realistic goals in terms of interest and ability.
5. To receive vocational guidance.
6. To assume responsibility for own acts and decisions.
7. To understand values of achievements and behavior.
8. To develop own interests, personal skills, and talents.
9. To have direction in critical thinking.
10. To develop a wholesome philosophy of life.
11. To develop leisure-time resources and cultural interests.
12. To develop a respect for work.

EXHIBIT XVII

Adapted Physical Education Recommendations

Name ______________________________ Birth Date __________

Address ______________________________ Phone __________

School __________________ Teacher __________ Grade __________

To Be Filled Out By the Physician

Diagnosis or description of the condition ______________________________
____
____

Condition: Permanent______ Temporary______

If temporary, may return to unrestricted activity ____________________.
(date)

Functional restrictions: Pupil's condition is such that the intensity and type of activity should be limited. He (or she) is capable of participating to the extent of:

____ Unrestricted physical activity

____ No competitive sports; in other activities, should stop short of excessive fatigue or undue stress.

____ No contact sports; other activity allowed.

____ Moderate exercise with all running, jumping, and gymnastics excluded.

____ Minimal activity; training in coordination only. Simple nonstrenuous activity (e.g. archery, ping pong).

____ Recommend the following exercise: ____________________
____

Musculoskeletal restrictions:

____ Avoid activities involving upper extremeties.
____ Avoid activities involving neck, back or abdomen.
____ Avoid activities involving the lower extremeties.

Comments: ____
____

Please call me if there is any questions about these restrictions.

Date ____________________ Signed ______________________________ M.D.

EXHIBIT XVIII

MEMORANDUM

TO: Dr. Tom Vernon
Preventive Medical Services Division

FROM: Michael E. Huotari
Asst. State Solicitor General

DATE: April 7, 1976

SUBJECT: Communicable Disease Reporting by Schools

This memorandum is in response to your inquiry concerning obligations of school districts to report communicable diseases.

As you are aware, C.R.S. 1973, 25-1-107(1)(a) authorizes the Department of Health to investigate and control causes of epidemic and communicable diseases. Pursuant to C.R.S. 1973, 25-1-108, the Colorado Board of Health has promulgated regulations requiring reporting of communicable diseases.

It is my understanding that certain school districts have indicated that they will not report communicable diseases on the ground that such action is prohibited by federal statute, 20 U.S.C. Sec. 123g (the Buckley-Pell Amendments). The federal statute does prohibit release of education records (i.e., records maintained by an educational agency which contain information directly related to a student). However, an explicit exemption is provided for release of information to state and local officials or authorities to whom such information is specifically required to be recorded or disclosed pursuant to state statute adopted prior to November 19, 1974. 20 U.S.C. Sec. 1232g (b)(1)(E). In addition, subsection (I) of the cited statute authorizes release of information in connection with an emergency if such information is necessary to protect the health or safety of the student or other persons.

Since the state statutes concerning communicable disease control were adopted prior to 1974, it is my opinion that information required under each statute comes within the exemption to the confidentiality requirement contained in the federal statute. Even if the routine disclosure of such information is not permitted by the federal statute, the department may utilize the emergency provisions. In addition, it is possible that the confidentiality requirement might be avoided by imposition of the reporting requirement for physicians contained in C.R.S. 1973, 25-1-649.

If I may be of further assistance in this matter, please contact me.

MEM:mb

EXHIBIT XIX

COLORADO DEPARTMENT OF HEALTH
4210 EAST 11TH AVENUE · DENVER, COLORADO 80220 · PHONE 388-6111
Anthony Robbins, M.D., M.P.A. Executive Director

FINDINGS AND ORDER OF QUARANTINE

The existence of a case of measles in the ______________________ (school) establishes the presence of a communicable disease which may be responsible for serious complications among unimmunized susceptible children. Complications may include death and encephalitis in as many as one in 1,000 infected children and otitis media, pneumonia, and other complications in as many as one in 200 infected children. Unimmunized susceptible children are subject not only to the effects of the disease and its complications but may be responsible for the transmission of the disease to other susceptible persons in the community, including unimmunized infants who have not yet reached the prescribed age for immunization.

The Colorado Department of Health hereby finds that the establishment of a quarantine is necessary for the protection of the public health. Therefore, pursuant to Colorado Revised Statutes 25-1-107 (b) and Colorado Revised Statutes 25-4-904, it is ordered that SCHOOL CHILDREN LACKING A RECORD OF ADEQUATE MEASLES IMMUNIZATION AS OF ______________________ (date) WILL BE REQUIRED TO REMAIN HOME FROM SCHOOL AND FROM ALL OTHER PUBLIC GATHERING PLACES UNTIL ADEQUATE IMMUNIZATION IS RECORDED OR UNTIL THE COMMUNITY IS DECLARED MEASLES FREE.

Colorado Department of Health
Division of Administration
Anthony Robbins, Executive Director

EXHIBIT XX

COLORADO DEPARTMENT OF HEALTH
Immunization Program

Suggested Quarantine Procedures

A. CONFIRM THE Dx!!!

1. Complete surveillance form
2. Determine date of onset of last case
3. Determine how many cases
4. Is quarantine feasible or is it too late?

B. Phone Immunization office for consultation and check on availability of vaccine and obtain quarantine order.

C. If decision to quarantine is made:

1. Clear with local health authority, i.e., Public Health Nurse, Director of local health department of County Health Officer, and school officials.
2. Notify local doctors of quarantine and the fact they may have some parents calling them for records and dates of immunization.

D. Review immunization records.

1. Obtain class lists
   a. check off those with adequate immunization
   b. send letter and questionnaire/consent form home to parents of children without adequate history or record
      1) Fill out child's name on letter
      2) Ask school personnel to distribute letters to students
      3) Ask principal and/or teachers to stress the importance of getting letter home because the child might be excluded from school
2. If no adequate records are in the schools (as in junior and senior high schools), send blanket letter and questionnaire/consent form requesting immunization histories or permission for administering shot.

E. Check returned slips with class lists and indicate immunization date or signed permission for shot at clinic. Use this list as a check-off at clinic. In an "open" school, each child will have to have his own slip in hand when he comes to clinic.

F. Conduct clinic

1. Check students off class list as they receive shot
2. At the end of clinic

  a. make up quarantine list and address letters for each child (including religious objectors)
  b. separate letters by class
  c. ask school personnel to distribute letters to students before close of school
  d. phone parents of absent children who are on quarantine list, if feasible
  e. ask school nurse to duplicate lists of students excluded for distribution to teachers

G. QUARANTINE DAY - Students on quarantine list are not to be admitted to class and should be sent home.

  1. Shots may be offered in case some students return with signed consent forms.
  2. Some students will bring immunization record.
  3. Reaction slips may be used to admit the above students to class by putting name of student and date of immunization on the reaction slip.

H. Subsequent Days

  1. School personnel may admit students showing proof of immunization.
  2. Maintain disease surveillance.

I. Lift quarantine 14 days after date of onset of last case.

Some Helpful Hints

1. Class lists furnished by schools are not always accurate. It helps to check lists with school counselors or office secretaries to eliminate students who have withdrawn and to add names of new students.

2. The news media should be kept well informed of the clinic and quarantine procedure through the Colorado Department of Health Public Relations office so that the public can be notified.

3. Because of possible spread of measles to siblings and subsequently to their schools, we recommend that the unimmunized family members of confirmed measles cases be quarantined.

4. Use of immune serum globulin is indicated only for school-age family contacts. This should be followed up with a measles shot in approximately 3 months.

5. When measles is identified in a community, infants from 6 months of age should be considered candidates for vaccine. Those receiving vaccine before 15 months of age should be reimmunized after that time.

6. Preschool children should be invited to attend measles clinics.

CHAPTER V

ROLE OF THE PHYSICIAN IN THE SCHOOLS

Written by:

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Children spend more waking hours in school in their first 18 years than in any other activity except watching television. During this time in school many dangerous or anxiety producing situations and multiple exposures to a myriad of infectious diseases will occur. Therefore, the physician who treats children will be involved with the schools whether he wishes or not. This chapter will discuss the four major ways a physician may be involved in the school.

I. As an employed school physician.
II. In a specified advisory or consultative capacity.
III. As a team physician.
IV. As a private practitioner and as a student advocate.

I. FULL OR PART TIME EMPLOYED SCHOOL PHYSICIAN

Only a few school systems in Colorado employ physicians since, except in the large metropolitan areas, school districts are of insufficient size to make it plausible or economical. Employed physicians do enhance school health programs and are desirable whenever possible. The duties of the employed school physician may be broken into four areas:

A. Consultation and Administration

1. Consult with administration concerning school health policy and practices including possible medico/legal problems.

2. Advise and consult with administration about specific school health practices and problems as they occur.

3. Maintain close communication with community physicians on both an individual basis and with them in their organizations - i.e. medical societies, specialty organizations. The school physician should communicate the nonschool physician's concerns to administration and vice versa.

4. Consult on validity and appropriateness of the various health programs proposed for introduction in the school.

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    5. Assist in recruiting new personnel for the school health program.
    6. Collect data for reports to the administration and public which will describe and evaluate the effectiveness of the school health program.

B. Health Service

    1. Implement and direct all health screening programs.
    2. See that special medical appraisals are completed by the appropriate individuals.
    3. Promote immunization of students both in private offices or in school or public health clinics.
    4. Recommend measures for control of communicable diseases within the school.
    5. Assist families in obtaining medical aid when necessary.
    6. Establish and supervise facilities and first aid programs in the school.
    7. Act as a liaison person between outside medical sources and the classroom teacher or other school personnel regarding specific pupil problems.
    8. Collaborate with special education director in the development of special education programs for medically handicapped individuals.

C. Health Education

    1. Advise on appropriateness of health education materials.
    2. Assist in planning in-service educational programming on health subjects for school personnel.
    3. Assist in planning and giving parent education meetings about school health problems.
    4. Serve as a resource person in development of new health education programs.

D. Administrative Relationships

    1. Be involved in formulation of school district policies or procedures concerned with children's health and safety.
    2. Be available to school district personnel who have questions relating to medical facts, procedures, policies and ethics.
    3. Have the opportunity to participate in policy making and program planning in all areas of the health program.

II. SPECIFIED ADVISORY OR CONSULTATIVE CAPACITY

Many physicians will work for schools in a nonpaid advisory or consultative role. They may do this individually, or in a group such as a school health committee or council.

As an individual, a physician may be asked to advise or consult because of his expertise in many areas. These areas may include - a) general pediatrics, b) growth and development, c) athletics, d) vision, e) hearing, f) neurology, g) learning disabilites. Many programs will need the advice of the physician in these areas for their initial development. Changes may need to be made and the physician's advice will be essential in making these changes intelligently. Advice should be given as able. It will be greatly appreciated by the school administration, the involved teachers and the individual students and parents.

Whenever possible, membership on school committees should include practicing physicians, local public health officials and employed school physicians, school nurses and members of the involved school district administration. School health committees should have specific objectives which should include the following:

A. Development of active lines of communication and periodic meetings with officials from the departments of health, education and from parent groups.

B. Development of collaborative projects with educators to study student health practices, services and health education.

C. Make suggestions about changing the above practices and programs when necessary.

D. Evaluation of laws and regulations governing school health issues in the particular state or political unit for which the committee is responsible.

E. Evaluation of local school board's school health policies and procedures and recommendations regarding change when it is deemed necessary.

F. Familiarizing local physicians about school health laws and regulations and new school related government health programs.

G. Assisting school nurses and health aides with their everyday problems in the school district. The School Health Committee members also function to interpret the health needs of the school to the community and to transmit the public's attitudes about school health to the school board and administration.

III. TEAM PHYSICIANS

Another way physicians will be involved with the schools will be as a team physician. Physicians should realize that being a physician does not automatically qualify him to be a good team physician. Special knowledge about athletes, the particular problems they face because of difference in ages in the various specific sports are available from a number of professional organizations such as the AAP, AMA, and AAHPER and should be sought out by those aspiring to be team physicians.

A. Primary Responsibility

The team physician should have a firm understanding, preferably written, with the school administrator delineating his duties and responsibilities, as well as the responsibility of the district to the physician. He should have final determination as to the physical and mental fitness of the athletes under his charge. He should be the first authority as to who may or may not participate because of physical or mental incapacity. This authority should be understood by the coaching staff, trainers, administration and other physicians practicing in the area.

The physician should be in attendance at all games and available during practice sessions. He should have the opportunity to evaluate the health of and review the examination of all candidates done by the student's private physician before the season opens. It is the duty of the team physician to keep abreast of current developments in sports medicine.

B. Relations with School and Community

1. Insure the presence or availability of emergency transportation at the game site.
2. Insure the availability of telephone communications at the game site.
3. Check all aspects of legal liability.
4. Insure that everyone understands that the team physician, while on duty is not a personal physician and that referrals to the athlete's personal physician remains the pupil's prerogative.
5. Attempts to make all recommendations in writing so they won't be misunderstood by parents, coaches or school officials.

C. Relationship with Athletic Trainer

Ideally, each school should have an athletic trainer. Practically speaking, this is impossible because of the limited number of trainers and financial problems in the schools. Schools lacking such a trainer should appoint a coach or another faculty member trained in First Aid and techniques to function as a trainer. Student trainers should be encouraged and trained when possible. The team physician should serve as supervisor and advisor to the athletic trainers. He should assist in establishing and monitoring a training room. He should make certain the trainer functions within the limits of his capabilities and keep a constant communication with him during the season.

D. Game Responsibilities

The team physician should arrive at the game site prior to game time. After arrival, he should introduce himself to the officials and check with them regarding availability of the telephone and transportation and to see if the visitors have their own physician. He should again check with the trainers and coaches regarding medical problems with the players. He should inspect the field and other conditions that may cause possible medical problems. He should use the team area as his base, stay off the field unless summoned by trainer, coach or officials. In order to observe the game more closely, he should move around the field as necessary. At halftime, he should check with coaches and officials regarding injuries and make recommendations regarding immediate and follow-up care. Rehabilitation of injured players is probably the weakest link in high school sports and should not be ignored by the team physician.

E. Injury Intervention

Injury prevention is a necessity in a well-organized sports program. Injuries will occur and the type and severity can be anticipated, depending on the particular sport. The following steps will help decrease their incidence.

1. Full history and physical examination.
2. Adequate practice equipment.
3. Adequate preseason conditioning.
4. Adequate knowledge of the individual sport and its rules.

F. Physician Legal Liability

The physician in his capacity as team physician has the same responsibility, obligation and duties that he has in his private practice only the fact that by being a team physician he has represented to the members of that team that he has professional qualifications to diagnose and treat the problems which are inherent in

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that sport. Although few suits have been filed and won against team physicians, the present day trend of suing for poor results will mean that more suits will be filed against team physicians. The following suggestions are meant to help team physicians.

1. Contract - The team physician should have a written contract with his school stating his duties and obligations clearly. The school's obligations to the physician should likewise be clearly spelled out in the contract.

2. Consent - Written consent for necessary procedures should be available from each team member prior to the beginning of practice. If no consent is obtained, the physician is open to damages of assault and battery by an aggressive attorney.

3. Insurance - A team physician should carry the limit in malpractice insurance. If your coverage or umbrella is less than $1,000,000, you are underinsured in view of the seriousness of certain head and neck injuries and their immediate and lifelong expectancies.

4. Practice defensive medicine.

Despite the above admonitions, being a team physician is a worthwhile, satisfying experience. The rewards will far outweigh the risks for those who try.

IV. THE PRIVATE PHYSICIAN AS A CHILD ADVOCATE

Private physicians are continually asked by students, parents and schools for their opinions regarding a child in the schools. The physician must carefully weigh all evidence collected during his deliberations. When he is making his decision he should remember that his duty is to the child, not the parents or the school, and his decision should be made accordingly. Staff conferences will often be held after a work-up on a child with problems has been completed. If possible the physician should attend this conference and give his opinion directly. It will mean more if he does.

Schools, with their "different" language, can seem like a confusing maze to the uninitiated physician. He should attempt to familiarize himself with the structure, the language and terminology of the schools. He can then aid the student as an advocate more effectively and will enjoy the process much more fully himself.

CHAPTER VI

HEALTH AIDES IN THE SCHOOLS

Purpose

In some school districts, because of the broadening functions of the school nurse and the shortage of qualified personnel available to provide services to an increasing school-child population, auxilliary personnel are being brought into the school health program to work under the supervision of the school nurse. They assist her in those duties that can be realistically assumed by a nonprofessional health assistant.

School health aides can free highly trained professional nurses from many routine tasks and thus make a valuable contribution to the school health program. Since the health aide is not professionally prepared, at no time should she be expected to provide any professional nursing service.

In order for a health aide to function appropriately in such a job, she should have preservice training in which she has learned, among other things, expectations and limits of the job. Since the school nurse is directly responsible for the health program in her school, the health aide must be directly under her supervision.

The school health aide program can be classified into three groups: 1) Paid school health aides, 2) Volunteer school health aides, 3) Student school health aides.

In the paid school health aide program, it is suggested that a health aide be paid a salary comparable to that of a teacher's aide. In student school health aide program, it should be arranged with the school administration for the student to receive an academic credit the same as for a student teacher's aide.

The duties and responsibilities of an adult school health aide and a student school health aide will vary. This must be taken into consideration when deciding the type of health aide program the school health program needs. The two different programs will be discussed on the following pages.

Adult School Health Aides

These guidelines for school nurse aide were prepared by the School Nurse Conference group of the Colorado Nurses' Association and are to be used by school administrators and school nurses in the hiring of school nurse aides. The use of school nurse aides will give school nurses time to expand their roles to include the consultative, counseling, evaluative, and educative functions which are necessary to the broadened concept of school nursing.

Qualifications

IT IS STRONGLY RECOMMENDED THAT THE CANDIDATE HAVE A SUCCESSFUL INTERVIEW WITH THE SCHOOL NURSE AND PRINCIPAL(S) PRIOR TO EMPLOYMENT.

1. Education
   - High school diploma or equivalent.
   - American Red Cross First Aid Certificates.
   - Adequate office skills.
   - License to drive and have own auto available with insurance coverage to meet district requirements.

2. Personal Factors
   - Dependability.
   - Reports as scheduled and maintains own time record.
   - Understands and follows school health policies, and assumes responsibilities assigned to her.
   - Able to work within confines of guidelines.
   - Informs the school nurse and/or designated school person when she leaves the health office.
   - Adaptability -
     - a. Ability to learn procedures quickly.
     - b. Capability of adjusting to various school buildings.

3. Interpersonal Relationships
   - Has a genuine liking for children and the ability to work with them.
   - Establishes rapport with students, parents, and school personnel to provide for student health needs.
   - Uses discretion and respects confidentiality of information entrusted to her.

4. Emergency Effectiveness
   - Exercises good judgment and intelligence when unexpected problems arise.
   - Requests additional assistance as necessary.

Duties

WITHIN THE FRAMEWORK OF EACH INDIVIDUAL SCHOOL, THE SCHOOL NURSE AIDE MAY PERFORM ALL OR A PORTION OF THE FOLLOWING:

1. Assists the school nurse in meeting the health needs of children.
   - Gives minor first aid to the sick and injured.
   - Contacts the school nurse, or designated person, in cases of major illness or serious injury.
   - Contacts the parent of the ill or injured student in accordance with established health office policy and, if necessary, prepare the student to go home.

- Transports sick or injured student as deemed necessary by school nurse.
- Confers with the school nurse regarding students' absences for health reasons (communicable disease, injury, hospitalization, etc.).
- Informs the teacher and other school personnel regarding disposition of students sent to the health office.
- Reports safety hazards.

2. Health Office Management

   - Keeps the health office attractive and orderly.
   - Participates in ordering and maintaining supplies, including first aid supplies throughout the building.
   - Maintains and files health office records.
   - Types letters, reports, and requisitions as directed by school nurse.
   - Schedules appointments for school nurse conferences with student, parent, teacher, etc.
   - Receives and relays telephone messages for the school nurse, and initiates telephone contacts as directed.

3. Assists the school nurse in scheduling and performing routine screening procedures, informing teachers and following up on referrals which were sent.

   - Perform initial screening tests on students as designated by school nurse.
   - Assists in distribution and collection of health appraisal forms.
   - Reviews health history forms and refers to the school nurse all pupils needing special follow-up.
   - Assists in communicable disease prevention by appraising immunizations needs of students. Makes referrals as indicated.
   - Observes the students for other health needs as they arrive in the health office.
   - Records health office visits, the students' symptoms, and the disposition made. Informs school nurse. Informs teacher as necessary.

4. Assists in health education activities.

   - Maintains and distributes health education materials as directed by school nurse.
   - Maintains bulletin boards in the health office.

Evaluation of the School Nurse Aide

The School Nurse Aide Evaluation is essential and should be used as a tool to assess performance and as a basis for improvement. The procedure for this is:

1. Each school nurse and school nurse aide will be oriented to the areas of responsibility.

2. The school nurse will provide a formal evaluation for the school nurse aide each semester based upon written observations and periodic conferences. At this time, future goals can be established.
3. Copies of the summary evaluation will go to the school nurse aide, the principal, and the school health program supervisor.

EVALUATION OF THE SCHOOL NURSE AIDE*

Name ______________________________ School Nurse Aide

School ______________________ District ______________

AREAS OF PERFORMANCE AND PERSONAL FACTORS	RATING SCALE			
	Unsatisfactory	Needs Improvement	Satisfactory	Excellent
1. Assists in meeting health needs of children				
2. Manages health office				
3. Assists with routine screening and follow-up				
4. Assists with health education				
5. Dependability				
6. Adaptability				
7. Interpersonal relationships				
8. Emergency effectiveness				

Evaluations of the above areas of performance and personal factors are based upon the following: ______________________________

____

____

____

Date of evaluation ______________ Signature ______________________ R.N.

Comments and summary by school nurse aide: ______________________

____

____

____

Signature ______________________

Use reverse side if necessary.

Reviewed by ______________________, Principal.

*Guidelines for School Nurse Aide will be used as basis for this evaluation.

Student School Health Aides

The students in this health aide program may be either junior or senior high students. Usually the junior high students serve their own schools, and senior high students serve the elementary schools and high school. Transportation to and from the elementary schools doesn't seem to be a problem for most high school students.

Qualifications

1. American Red Cross First Aid certificate.

2. Commitment to the job.

   - Be punctual and when absent, call in.
   - Keep an accurate record of working hours in designated place.
   - Understand the seriousness and responsibility of the job.
   - Be willing to work hard.
   - Have a liking and respect for children.
   - Keep information confidential.
   - Observe safety for self and for the students.
   - When in doubt, ask direction from supervisor in charge.

Duties

1. Answer the telephone, identify self, record message.

2. Check temperature of anyone complaining of "not feeling well."

3. Give minor first aid to the sick and injured.

4. Contact the school nurse, or designated person, in case of major illness or serious injury.

5. Keep the health office attractive and orderly.

6. Notify school nurse of needed first aid and other supplies.

7. Assist in performing school health screening programs.

8. Plan attractive bulletin boards, discuss theme with school nurse and get her approval.

9. Supervise the health office when the school nurse is out for other duties.

10. Maintain and distribute health education materials as directed by school nurse.

11. Record the name of each student who comes to the health office, time, their complaint, what was done for the student, and the time they returned to class or went home.

Health matters are confidential, therefore, the health records are not handled by students.

There is an application form for student health aides on the following page.

The recommendations for the student school health aide program was adapted from the program used by the Denver Public Schools.

APPLICATION FOR STUDENT HEALTH AIDES

(print all information)

1. Name ____________________ Your present grade level __________
2. Address ____________________ Phone __________
3. School ____________________
4. Home Room Teacher ____________________
5. Age __________ Date of birth __________ Height ______ Weight ______
6. Father's name ____________________ Occupation __________
   Address ____________________ Phone __________
7. Mother's name ____________________ Occupation __________
   Address ____________________ Phone __________
8. Are you living with both parents? ____________________
9. Number of brothers and sisters living at home? ____________________
10. How many days have you been absent this year? ____________________
11. Do you have any physical disability? _____ If yes, explain: __________
    ____
12. What type of transportation do you have? ____________________
13. List your present class schedule:

Period	Course	Teacher	Room No.

14. List courses that you have completed which are related to your choice of training:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

15. In what extracurricular activities have you participated? ____________________

____

16. What extracurricular activities will you participate in this year? __________

____

17. What are your hobbies? ____________________

18. What typing skills do you have? ____________________

19. Have you done any filing? _____ Explain ____________________

20. PAST WORK EXPERIENCE: (list most recent job first)

Employed by	Employer/Supervisor	Type Work Performed	Date

Signed ____________________

Date ____________________

SCHOOL HEALTH PROGRAM
SCHOOL HEALTH AIDE WEEKLY ACTIVITY REPORT FORM

Aide________________________ School________________________ Month_______________ Year_____

Date:	Monday		Tuesday		Wednesday		Thursday		Friday		TOTAL	T L
TYPE OF ACTIVITY	No.	Time	No.	Time	No.	Time	No.	Time	No.	Time	No.	Time
STUDENT CONTACTS A. Illness												
B. Injury												
C. Med.Assisted												
D. Vision Scrn.												
E. Hearing Scrn.												
F. Transport												
G. Class Assist	▨		▨		▨		▨		▨		▨	
*H. Other												
PARENT CONTACTS A. Phone												
B. At School												
C. Home Visit												
CONFERENCES WITH SCHOOL PERSONNEL RE: STUDENTS OR PROGRAMS												
STAFF DEVELOPMENT A. Orientation	▨		▨		▨		▨		▨		▨	
B. Staff Mtg.	▨		▨		▨		▨		▨		▨	
C. Supv. Conf.	▨		▨		▨		▨		▨		▨	
D. Inservice	▨		▨		▨		▨		▨		▨	
CLERICAL WORK	▨		▨		▨		▨		▨		▨	
REFERRALS MADE TO: A. School Nurse		▨		▨		▨		▨		▨		▨
*B. Other		▨		▨		▨		▨		▨		▨
MISC. A. Maintaining Health Room	▨		▨		▨		▨		▨		▨	
B. Bulletin Boards	▨		▨		▨		▨		▨		▨	
C. Completing Report Form	▨		▨		▨		▨		▨		▨	
*D. Other	▨		▨		▨		▨		▨		▨	
TOTAL	▨		▨		▨		▨		▨		▨	

*Explain on the back the type of activity giving the specific date.

CHAPTER VII

PROCEDURES AND REFERRAL BASIS FOR SCREENING PROGRAMS

Introduction to Screening Programs

Screening for health problems is an appropriate function of the school nurse. Diagnosis and treatment is the function of the physician.

This chapter on screening procedures provides what is hoped will be an easy-to-use format. Step-by-step directions for each screening procedure are included in addition to other pertinent information which will be useful to the school nurse. Incorporated into each segment of the screening section is information as to who is to be screened and at what intervals, special alerts, the conditions and equipment needed, "cook book" directions on how to do each procedure, how each procedure is scored and recorded, when the patient should be referred for diagnosis or further evaluation, the resources available for diagnosis and treatment, incidence and some thoughts on the significance of preventive care in the particular problem being screened for. Each screening procedure is described in this same order so that information will be easy to find and to follow.

What is screening and why should you do it? Screening is designed "to move up in time the usual time of diagnosis of disease."[8] If we can identify a potentially handicapping condition before it becomes symptomatic, then diagnosis and treatment can be undertaken at the optimum time, and sometimes at less cost. You do screening because it is an easy, relatively inexpensive way to sort out from a large number of apparently well people, those who may be at risk of having a potentially handicapping condition. Screening makes for a more careful expenditure of scarce resources because elaborate and costly diagnosis procedures are reserved for those persons identified as being most likely to have a potentially handicapping condition. Additionally, people at low risk are spared the trouble of undergoing such procedures.

Decisions to be made before embarking on a screening program are decisions as to what diseases or conditions will be screened for and what screening procedures should be used to identify such conditions. This manual reflects the thinking of the Colorado Department of Health on both these considerations. However, it should be noted that vision and hearing screening are mandated by Colorado law for school children.

It may be of interest to examine the criteria established by Frankenburg and Camp[9] in these connections. Their criteria for selecting diseases to be screened for:

1. Condition treatable or controllable
2. Early treatment improves outcome
3. Screening time adequate
4. Firm diagnosis possible
5. Condition relatively prevalent
6. Condition serious

For selecting which screening procedures are to be used, they suggest these criteria:

1. Acceptability, to professionals and to the public
2. Simplicity, requiring no complicated or hard-to-move equipment
3. Reliability, or repeatability of results
4. Validity, the frequency with which the screening test result is confirmed by the diagnosis
5. Appropriateness for the population being screened
6. Cost

The school nurse who plans a screening program has a responsibility in addition to making decisions about what conditions to screen for and what screening procedures to use. She needs to give some thought to the implications of such a program for the patient being screened. In a screening program, it's well to remember that the nurse takes the initiative, not the patient. She assumes responsibility for seeking out potential problems in an asymptomatic person. Before undertaking to do so, she must weigh the discomfort, inconvenience and anxiety, caused by the screening process, against the benefits to the patient of knowing that a problem condition exists.

The nurse's decisions about these concerns may rest upon the following considerations:

1. Medical knowledge should be adequate to deal effectively with a problem which may be identified.
2. Health care providers should be available to deal with any problems she discovers and other facilities (such as laboratory, hospital, etc.) should be accessible.
3. Financial resources should be available to pay for diagnosis and treatment.
4. She should have the time and the knowledge to assist the family in finding and using available resources.

There are some difficulties which commonly occur in screening programs which the school nurse may want to consider as she plans. Since the success of any screening program ultimately depends upon securing the cooperation of the patient and of physicians and others who may be participating, it is essential to design a program which meets their needs. Arrangements which cause problems (delays, inconvenience, what may appear to be unnecessary red tape) may lessen willingness to participate and thereby limit the effectiveness of the program. Careful planning can reduce such problems. Here are some steps[10] which should be helpful:

1. Use simple administrative procedures. Complicated ones may discourage students; time consuming ones may not be practical in the school setting.
2. Avoid unnecessary delays. Long time lapses between the screening and the start of evaluation/treatment makes the student and parent think the problem is not very important.
3. Eliminate unnecessary referrals.

4. Communicate fully with student, parent and physicians.
5. Provide both setting and staff conducive to the comfort and self-esteem of the student.
6. Avoid duplication of services provided.
7. Provide supportive services when possible; i.e. translators, transportation.
8. Protect confidentiality.
9. Know what resources are available in your community.
10. Work with the community to help get new resources going.

The screening procedures included in this chapter cover the most common types being conducted in Colorado schools. They are, in the judgment of the Colorado Department of Health, Community Health Services, the best presently available.

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8. Frankenburg, W.H. and Camp, B.W., Pediatric Screening Tests. Charles C. Thomas, Publisher, Springfield, Illinois, 1975.

9. Ibid.

10. Adapted from EPSDT Screening Guide, H.E.W.

VISION SCREENING

Who is to be screened:

- Vision screening is to be done at Kindergarten and 1st, 3rd, 5th grade levels, once at junior high level, once at senior high level, for all children new to the school system, and for all children referred by school personnel.

- Vision screening should be provided for all high-risk children including:

  - Those who are enrolled in special education programs
  - Those who repeat a grade
  - Those who failed vision screening during the previous school year and did not get glasses

Special alerts

- Crossed eyes
- Red-rimmed, crusted or swollen eyelids
- Inflamed or watering eyes
- Recurring styes
- Complaints of double or blurred vision
- Complaints of itching, burning or scratchy eyes
- Complaints of dizziness, headaches, or nausea, following close work
- Inability to see well at near or far distance
- Squinting or frowning
- Blinking
- Rubbing eyes excessively
- Straining to see (shutting one eye, tilting head, thrusting head forward)
- Drooping eyelid(s)
- Holding book too close
- Stumbling over small objects

What conditions are necessary?

- Adequate lighting
- Room large enough to permit examiner to be at required distance from child. For regulation Snellen E, 20 feet.

Necessary equipment

- The Snellen tests and personal observation have proven to be the two most reliable methods of identifying children with visual problems in the school setting.

- Tape measure

- Occluder (may be paper cup or paper patch to be held lightly over one eye at a time)

Procedure

- Snellen E test (for visual acuity) establishes level of child's visual acuity; i.e. 20/20, 20/40, etc.

- Be sure light is sufficient to illuminate the chart, but avoid glare on chart or in child's eyes.

- Place chart on light-colored wall at child's eye level.

- Have child stand with heels on a line 20 feet from chart.

- Show the child what you expect him to do:

  1. "This is an E. See which way the E is pointing. Show me with your fingers how the E is pointing."

  2. Be sure the young child understands "the E game" and can show you which direction the E is pointing.

  3. You may let him use a wooden block E to point with.

  4. Demonstrate how to use the occluder.

- Test with both eyes open, then test the right eye and finally the left.

- Test from the top of the chart (larger, easier-to-read letters first) down toward bottom (small, more-difficult-to-read letters).

- Use a snake pattern: left to right, right to left, left to right.

- Test a child to his expected vision, based on his age:

Age 3	expected: 20/40	test 70, 50, 40 lines
Age 4 and 5	expected: 20/30	test 50, 40, 30 lines
Age 6 and up	expected: 20/20	test 40, 30, 20 lines

- Cover test (for nonstraight eyes, amblyopia).

  - Tell the child what you are going to do.

  - Using a penlight held 1 ft. to 1-1/2 ft. from his face, ask him to look at the light with both eyes open.

  - Cover, then uncover one eye with your hand. Do not touch the child's eye.

  - Observe the eye being covered and uncovered. These conditions may be observed:

1. The eye may be properly aligned, signifying straight eyes.

2. The eye may move as it is uncovered, indicating that it drifted out of line while it was covered. Movement may have been in toward the nose, out toward the ear, up or down. This would indicate nonstraight eyes.

. Repeat the procedure on the other eye.

. Pupillary light reflection test (for nonstraight eyes)

1. Tell the child what you are going to do.

2. Holding the penlight 1 ft. to 1-1/2 ft. from the child's face, observe the dots of light reflected back to you from his pupils.

3. If the child's eyes are straight, the two lights will be in the same place on both pupils or they will be both slightly toward the nose side of the pupil, symmetrically.

4. If the child's eyes are not straight, the dots of light will be off center in one pupil, or not symmetrical (parallel).

Scoring and recording test results

Scoring:

. The Snellen E test is scored with two numbers, i.e. 20/20, 20/40, etc. The 20 at the top of the equation represents the 20-foot distance the child stands from the E chart; the lower figure refers to the line in which the child reads more than half of the letters correctly. A 20/40 score, then, indicates that the child can read the 40 line at 20 feet. Expected visual acuity is related to the age of the child, as outlined above. In order to pass a line on which he is being tested, he must correctly identify more than half the E's with both eyes together and with either eye alone.

. Cover test is scored "pass" if the eye being uncovered remains aligned with the other eye. It's a "fail" if there is movement (in or out, up or down) of the eye as it is uncovered. This movement must be observed more than once; it must be consistent.

. Pupillary light reflection test is a "pass" if the dots of light are centered in each pupil or are slightly toward the nose side, equally distant in both eyes.

. Vision screening results should be recorded on the student's individual health record.

When to refer

- The testing should be repeated on those students failing original screening.

- Refer if there is possible muscle imbalance as shown by failing either the cover or the puillary light reflection test.

- Refer on the visual acuity test according to the following formula:

1. Snellen E test

   - Refer a child 3 years old who fails the 50 line with either eye.

   - Refer a child 4 or 5 years old who fails the 40 line with either eye

   - Refer a child 6 or older who fails the 30 line with either eye.

   - Refer any age child who has a two-line differential between the eyes, as this may also indicate the development of amblyopia. Examples:

LE	20/20	RE	20/40
LE	20/30	RE	20/50
LE	20/40	RE	20/70

Incidence

- One child in twenty have vision problems.

Resources

- Handicapped Children's Program will, under certain circumstances, offer assistance for the child with strabismus, cataracts, glaucoma, and some other eye problems requiring surgery. The cost of diagnosis, treatment and glasses may be provided by H.C.P.

- Another resource may be the local Lions Club if it has a vision conservation program.

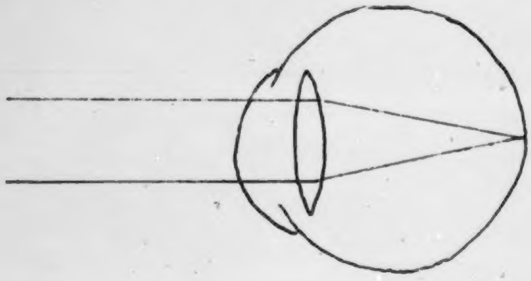
Significance of preventive care

- Preventive care of the child's eyes and vision is crucial if permanent impairment of his vision, as occurs with untreated amblyopia and strabismus, is to be averted.

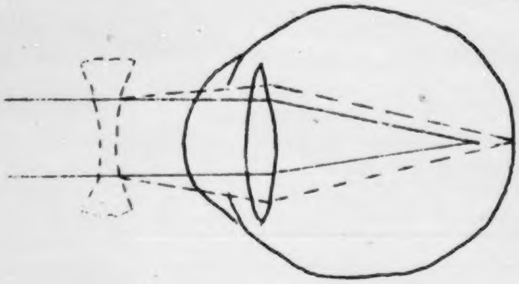
- Crossed eyes are a social handicap which can be prevented with treatment.

- Poor visual acuity may interfere with a child's success in school but may be avoided if this vision can be helped with eye glasses.

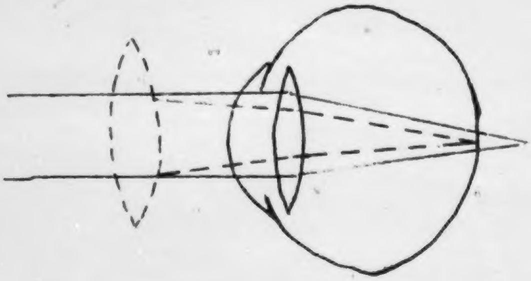
Normal vision and refractive errors



Normal eye: image forms on the retina.



Myopia (near sightedness): eyeball too long and the image forms before the retina. The person with myopia may be able to see well at near distance, but cannot see far away. Correction with a concave lens is shown by the dotted line.



Hyperopia (farsightedness): eyeball too short and the image forms behind the retina. The person with hyperopia may be able to see well at a distance, but will have difficulty seeing when doing close-up work. Correction with a convex lens is shown by the line.

HEARING SCREENING

Who is to be screened?

- Hearing screening is to be provided for all students in grades Kindergarten, one, two and three, plus once at the junior high level and once at the senior high level, for all children new to the school system, and for all children referred by classroom teachers or other school personnel.
- Hearing screening should be provided for all high-risk children including:
  - Those who are enrolled in special education programs
  - Those who repeat a grade
  - Those who failed a threshold test during the previous school year
  - Those who have a medical problem associated with hearing impairment

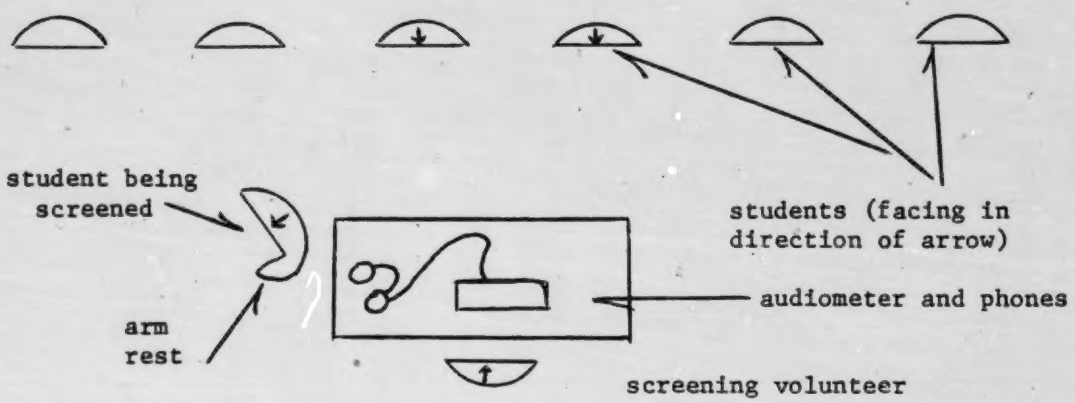
Special alerts

- Sudden hearing loss
- Failure to develop speech, or delayed speech
- Turning head to hear with one ear
- Suspicion that the child is lip-reading
- Child sometimes appears to ignore or misunderstand instructions
- Low tolerance for loud sounds
- Child turns TV or radio volume up very loud
- Discomfort in ear
- Draining ear

What conditions are necessary

A quiet room free as possible from conversational distractions, machine noises, telephone and building sounds, such as humming lights, fans, etc.

Below is a suggested arrangement for seating where space permits. One child is screened at a time and care should be taken that he not be able to see other children or the control dials on the instrument (thus the angle of the chair). A group of six to eight children entering the room at one time is a time saver. As each is screened, he can be dismissed. When only one remains, a new group can be seated.



Necessary equipment

- A Puretone audiometer which has been callibrated and allowed to warm up for five minutes. Machine should be left on during a screening day unless it is battery operated.

- Table, two chairs.

Procedure

- Seat the child in profile to the screener so that he cannot see the screener's hands or eyes.

- Give simple but complete instructions, such as: "I want you to listen very carefully. You will hear a tone in one ear at a time; sometimes loud and sometimes very soft. Whenever you hear a tone, raise your hand. Leave your hand up as long as you can hear the tone; put it down when the tone stops."

- Place the earphones on child's head; red on the right ear, blue on the left. Be sure each earphone is centered over opening of the ear. Hair must be out of the way.

- Test the right ear first as a matter of standard procedure.

- After the right ear is screened, switch the phone control for the left ear and screen for the left ear.

- Set the tone switch in the "normal-off" position, so that the tone will sound only when the interrupter switch is pressed down.
- Do not present the tone in a rhythmic pattern. Both the length of the tone and the interval between tones must be varied continually. Child must indicate both beginning of this awareness of the tone and the time when he can no longer hear it.
- Test for the 2000Hz tone first at 20 dB. Then test for response to 4000 Hz at 25 dB, 1000 Hz at 20 dB and 500 Hz at 25 dB. (ANSI-1969)
- Begin offering the sound at 35 decibels to acquaint the child with the tone he's listening for. Then move to the softer sound for screening. If room is too noisy to screen at these levels, find a better room.
- Work quickly; offer praise. This helps the young child "stay with you" as you test.

Scoring and recording test results

If the child fails any frequency in either ear, he should be rescreened. If the rescreening continues to show him failing, his hearing screening should be scored "fail."

Hearing screening results should be recorded in the student's individual health record.

When to refer

If the child fails the initial and second screenings, he should be referred for evaluation to an audiologist or person trained in threshold testing.

Incidence

In Colorado, records indicate that for the past 20 years, between 3-5% of school-age children have some hearing loss; among preschool children the incidence is about 20%.

Referral resources

If the school district has an audiologist, the student should first be referred there for threshold screening. Local health departments, private physicians and audiologists, and universities may be resources. The Handicapped Children's Program at the State Health Department may be able to assist with evaluations, hearing aids, speech therapy, etc., depending upon individual circumstances. The local HCP staff can help facilitate requests for service from the state level.

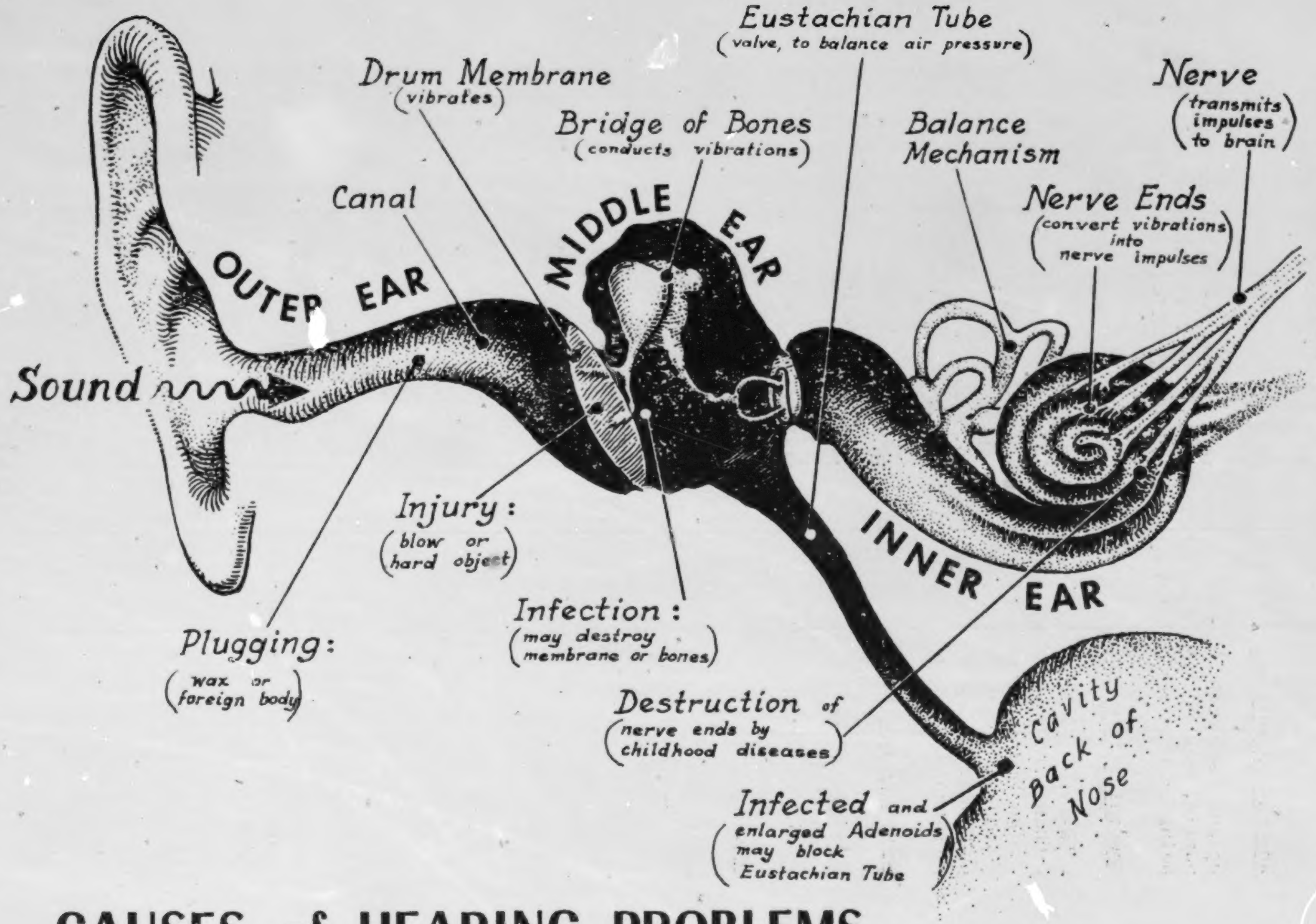
Significance of preventive care

Preventive care in detecting hearing loss is significant because:

- Ear infections which may cause deteriorating hearing if allowed to become chronic can be averted.
- Speech, language and hearing problems can be reduced during critical learning periods.
- Learning disabilities which would interfere with a child's schooling can be prevented or reduced.
- The child can be spared the social and emotional trauma of hearing impairment.

See diagram on the following page for "Causes of Hearing Problems."

DIAGRAM of EAR


Eustachian Tube
(valve, to balance air pressure)
Drum Membrane
(vibrates)
Bridge of Bones
(conducts vibrations)
Balance Mechanism
Nerve
(transmits impulses to brain)
Canal
MIDDLE EAR
Nerve Ends
(convert vibrations into nerve impulses)
OUTER EAR
Sound
Injury:
(blow or hard object)
INNER EAR
Infection:
(may destroy membrane or bones)
Plugging:
(wax or foreign body)
Destruction of
(nerve ends by childhood diseases)
Cavity Back of Nose
Infected and enlarged Adenoids may block Eustachian Tube

CAUSES of HEARING PROBLEMS

HEIGHT AND WEIGHT SCREENING

Who may be screened?

Height and weight is recommended to be taken for all elementary school pupils, as well as for any pupil having a school health appraisal or being staffed for the Handicapped Children's Educational Act.

Special alerts

- Failure of child to grow heavier, taller
- Change in growth pattern
- Significant differential between height and weight
- Unusual increase or decrease in weight
- Unusual increase or exceptional increase in height
- Unusual largeness or smallness of child

Necessary equipment

- Adult scales
- Nonstretch tape measure
- Height-weight charts for boys and girls

Procedure

- Height -
  Measure student either against a wall or on an upright scale with shoes off.
  Wall: Student's heels, buttocks and shoulders should touch the wall. Measuring tape should touch the floor at one end and be held or fastened perpendicular to the floor and straight.
  Upright scale: Student should stand straight with head up and feet together.

- Weight -
  Balance scales before weighing child.
  Have student remove shoes and heavy clothes.
  Instruct student to stand still while being weighed.

Recording the measurement

- Record the height and weight on the student's individual health record. Note the recordings of previous times and if there is any questionable finding, graph all measurement on a height-weight chart.

- If your graph shows a significant decrease in any measurement, repeat it right away to rule out measuring error.

- If there is a real discrepancy between height percentile and weight percentile, measure the student again.

When to refer

Refer when the student's measurements are outside the 3rd to 97th percentile or when there are any of the special alerts mentioned at the beginning of this section.

Incidence

Statistically there will be some 6% of children whose measurements are outside the 3rd and 97th percentile. Some Hispano or Asiatic children may be of smaller stature than the group of children from which the norms were established and this may be taken into consideration.

Significance of preventive care

There are a variety of disease entities which we might suspect if we see these conditions. The school nurse should evaluate the data to determine the need for referral.

- Underweight or overweight
- Extremely tall or short stature

Height and weight charts are included in Chapter VIII.

DENTAL SCREENING

Who may be screened?

Students at these grades and other students upon referral:

> Kindergarten, 3rd, 5th, one grade at junior high level and one grade at senior high level.

Special alerts

- Inflammation of gums (red, swollen, bleed easily, tender to touch)
- Stains on the teeth (black, brown, orange, or green)
- Breath odor
- Hard deposits of tartar on teeth (calculus)
- Obvious holes in teeth
- Missing teeth or extra teeth
- Noticeable protrusion of upper or lower jaw
- Sores in mouth
- Irregular alignment of teeth
- Thumb sucking
- Deviate swallowing (tongue thrust)
- "Bottle-baby syndrome" (rampant caries in upper teeth, sometimes as early as 18 months)

What conditions are necessary?

- Handwashing facilities
- Adequate lighting

Necessary equipment

- 2 chairs - one for examiner, 1 for patient
- Tongue depressors
- Penlight or good overhead lighting
- Wastebasket

Procedure

- Determine age of child, date of last visit to dentist.

- Have child tilt head back so that upper jaw and teeth may be examined. Rest his head against the back of chair, or if he's sitting on his mother's lap, against her, so that he will be comfortable and steady.

- Look at the color and appearance of lips, mucosa, tongue, palate, floor of mouth. Check for lesions, infections, neoplasms, and using tongue blade or finger, examine tooth surfaces facing the cheek.

- Observe chewing surfaces of the teeth and surfaces facing the tongue.

- Ask patient to bite his teeth together and note whether any lower teeth are outside the upper teeth. Check for the presence of two teeth in the space for one or for overlapping teeth.

Scoring and recording results

Mark dental problems on a copy of the dental chart included at the end of this procedure. Retain this in the child's records.

Copies of these charts may be obtained from the Dental Section, Colorado Department of Health.

When to refer

Refer for cavities, malocclusion, fistulas at root tip, irregularity in alignment, missing permanent teeth, inflammed gum tissue.

Incidence

Dental caries:

> Children 6-11 had an average of 1.4 decayed, missing or filled permanent teeth, and an average of 3.0 decayed, exfoliated or filled primary teeth. 70% of all children 6-11 had decayed, missing or filled teeth and just over 50% had decayed, not treated, teeth.[11]
>
> 50% of 2-year-olds have decayed teeth. Average 6-year-old has three decayed teeth.[12]
>
> White children have more tooth decay than Blacks; girls more than boys. In communities without fluoridated water, 8.3% of 18 to 23-month-old children had dental decay as did 57.2% of 36 to 39-month-old children. Children in communities with fluoridated water have 60% fewer cavities.[13]

Periodontal disease:

> Not as serious a problem in children as in adults, but because of its progressive nature, should be screened for early in life.

Malocclusion:

> 20-80% have malocclusions serious enough to warrant treatment.[14]

Referral resources

Private dentists, local health departments.

Significance of preventive care

Early detection while conditions are easier to treat helps prevent serious problems later. A dental problem is one health problem which will become more serious if untreated.

---

[11] Frankenburg, W.H. and Camp, B.W., Pediatric Screening Tests. Charles C. Thomas, Publisher, Springfield, Illinois, 1975.

[12] American Dental Association pamphlet, Dental Health Program for Children.

[13] Frankenburg and Camp, op. cit.

[14] Ibid.

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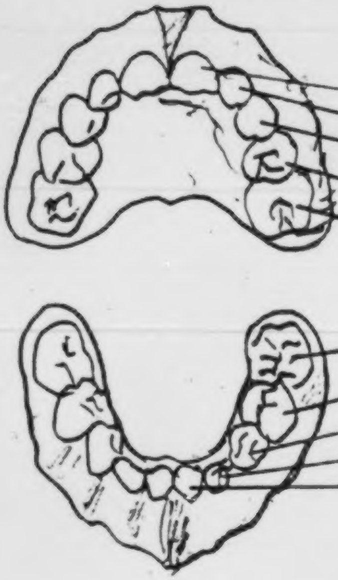
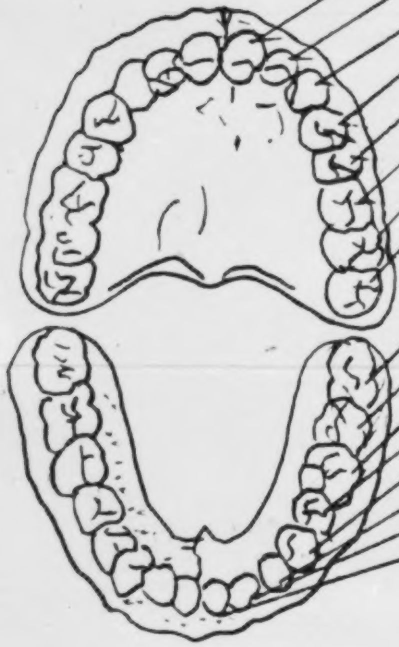
PERMANENT MOLARS DO NOT REPLACE PRIMARY TEETH



ERUPTION AND SHEDDING OF DECIDUOUS TEETH

UPPER	ERUPTION	SHEDDING
Central incisor	7½ mo.	7½ yr.
Lateral incisor	9 mo.	8 yr.
Cuspid	18 mo.	11½ yr.
First molar	14 mo.	10½ yr.
Second molar	24 mo.	10½ yr.
LOWER		
Second molar	20 mo.	11 yr.
First molar	12 mo.	10 yr.
Cuspid	16 mo.	9½ yr.
Lateral incisor	7 mo.	7 yr.
Central incisor	6 mo.	6 yr.

ERUPTION OF PERMANENT TEETH



UPPER	
Central incisor	7-8 yr.
Lateral incisor	8-9 yr.
Cuspid	11-12 yr.
First bicuspid	10-11 yr.
Second bicuspid	10-12 yr.
First molar	6-7 yr.
Second molar	12-13 yr.
Third molar	17-21 yr.
LOWER	
Third molar	17-21 yr.
Second molar	11-13 yr.
First molar	6-7 yr.
Second bicuspid	11-12 yr.
First bicuspid	10-12 yr.
Cuspid	9-10 yr.
Lateral incisor	7-8 yr.
Central incisor	6-7 yr.

SCOLIOSIS SCREENING PROCEDURE
Recommended by Handicapped Children's Program
Colorado Department of Health

Who to screen

- All boys and girls in 5th, 6th and 7th grades.
- All siblings of known scoliosis patients, even if not in designated grades.
- Those known to have scoliosis in 5th, 6th, or 7th grade who have not been treated with a brace or surgery, but who have not been screened. Reason: to get more accurate statistics.

Who screens

- Volunteers
  1. Use for initial screening.
  2. Give them general inservice on scoliosis prior to screening.
  3. Give them outline of specific areas to screen.
  4. Use of screening grid may be helpful to them.

- Designated Professional Screeners
  1. May do all of the screening.
  2. Should rescreen all those students "failed" by the volunteer screeners.

Screening set up

- Boys strip to waist.
- Girls leave bra on or request that they wear a halter or bathing suit so their back is bare. If this is objectionable, a plain color body suit or tight T-shirt will be adequate.
- Better to screen boys and girls separately.
- Screener sit in chair with screening grid between him/her and the student. If no grid is used position of screener and student is the same.
- Student stand erect with feet together and weight EVEN on both feet. Arms down at side and relaxed. Should be 5 to 8 feet between screener and student. Tape on floor can mark the position.

How to screen

- First screening position.
  1. Student stands with back to screener.
  2. Screener checks for the following:
     a. Unequal shoulder levels.
     b. One shoulder blade protruding more, or higher.
     c. Uneven or greater crease at one side of waist.
     d. Unequal distance between arms and body and apparent unequal length of arms as arms hang straight down from side.
     *e. Use plumb line to check if spine is straight. Cannot be used with screening grid. Hold string on vertebral prominence at base of neck. Let weighted end fall free. Check to see if spine deviates outside of the plumb line. (OPTIONAL)

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- Second screening position.
  1. Student faces screener in "forward bend position" as follows: Student bends at waist to 90°. Feet are together, knees straight, arms hanging in front with palms together. Screener remains sitting.
  2. Check for the following:
     a. "Rib hump" - one side of back higher than the other.
     b. Compare levels of two sides of back.
     c. Check for a hump in both upper and lower back.
     d. Hump may be very mild or prominent.
     e. Rib hump may be checked by looking at student from the back, using the same forward bend position.

Failures

- Volunteer screeners
  All those students who fail any part of the screening should be rescreened by the school nurse or designated professional screener.

- Designated professional screener
  1. Initial screening
     a. *Fail all students who have a rib hump, no matter how small.
     b. If one or more deviations are noted in the first screening position, check the student again and be sure he is standing with weight even on both feet. If deviations are still noted:
        (1) Rescreen in 6 months, if possible.
        (2) Be sure to include this student in the screening the following year no matter what grade they are in.
  2. Rescreening of students "failed" by the volunteers.
     a. Check students in both positions.
     b. *Fail all students who have a rib hump.
     c. Rescreen in 6 to 12 months those students who show other deviations.
  3. Note reason for failure on your classroom roster. This information will be needed on the Scoliosis Screening Report form (HCP:7) under history and will save you from seeing the student again.

Follow-up

- A personal contact with the child who fails and his parents should be made to explain the findings, significance of scoliosis, the need for a confirmed diagnosis and, if indicated, treatment and to determine the parents' choice of physician.

- Screening X-rays are desirable for follow-up. A screening X-ray is an AP standing X-ray which confirms the presence or absence of scoliosis or other spine abnormalities.

- For any child with more than a 10° curve the recommendation usually is that a diagnostic evaluation should be done. When treatment is recommended, support encouragement and teaching to the child, his peers, family and teachers should be part of the follow-up. Treatment usually continues until growth is completed. Because of the lengthy treatment, discouragement often results in a failure in completion of treatment.

*Note: A rib hump is really the only hard criteria for failure.

- A report such as the following form* Scoliosis Screening Report should be sent to the physician of choice as designated by the child's parents.

- Children who are financially eligible may be referred to the Handicapped Children's Program for all services needed for the treatment of scoliosis. Referrals to the HCP program may be made by physicians, school or public health nurses, or family members.

*This form may be obtained from the Colorado Department of Health, Handicapped Children's Program, Form #HCP:7. It is printed on NCR paper. We recommend that four copies be made for each child who fails the screening. Copies are for school record, child's physician, physician reading the X-ray, and Colorado Department of Health, Handicapped Children's Program, 4210 E. 11th Avenue, Denver 80220.

SCOLIOSIS SCREENING REPORT
(Failures Only)

Patient #________

Name ____________________ Birth date ________ Age ___ Sex M ___ F ___

Parents ____________________ Address ____________________

School ____________________ Grade ___ Family Physician ____________

County ____________

School Year ________

Ethnic Background:
1. Mexican Amer. ___
2. Black ___
3. Indian ___
4. White ___
5. Oriental ___
6. Other ___

HISTORY

Failure Reasons, Symptoms, Complaints ____________________

Prior Awareness: No___ Yes___ How Long ____________

Family History of Scoliosis (state relationship to student) No___ Yes___

Remarks ____________________

X-Ray Refused ______ Under Care Prior to Screening _____ Other Reason X-Ray Not Taken ____________

SCREENING X-RAY REPORT

X-Ray Taken at ____________________ Read by ____________

X-Ray Results:
1. Negative ____
2. Scoliosis ____

Degree of Curve:		Type of Curve:	
1. Less than 10^o	_____	1. Thoracic	_____
2. 10^o to 20^o	_____	2. Double Major	_____
3. 20^o to 40^o	_____	3. Thoracolumbar	_____
4. 40^o to 55^o	_____	4. Lumbar	_____
5. More than 55^o	_____	5. Other	_____

3. Kyphosis/Lordosis _____
4. Other ____________________

RECOMMENDATIONS

1. Discharge ____________ 2. Rescreen next year ________

Repeat AP Standing X-Ray: 3. 6 months _______ 4. 12 months _______ 5. Other ____________

6. Refer for Orthopedic Evaluation ________ 7. Other ____________________

____
Physician's Signature

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____
Date

HCP:7

SCOLIOSIS SCREENING PROGRAM SUMMARY

SCHOOL YEAR ____________ SCHOOLS INCLUDED ______________________________

GRADE: 5___ 6___ 7___ OTHER ____________________ ______________________________

SUBMITTED BY ______________________________

				SCREENING RESULTS				
			*	**	FAILED SCREENING			
AGE		TOTAL NUMBER SCREENED	TOTAL NOT SCREENED	QUESTIONABLE NOT REFERRED	X-RAYED	REFUSED X-RAY	NOT X-RAYED OTHER CARE	TOTAL FAILED
8 yrs.	MALE							
	FEMALE							
9 yrs.	MALE							
	FEMALE							
10 yrs.	MALE							
	FEMALE							
11 yrs.	MALE							
	FEMALE							
12 yrs.	MALE							
	FEMALE							
13 yrs.	MALE							
	FEMALE							
14 yrs.	MALE							
	FEMALE							
15 yrs.	MALE							
	FEMALE							
Other yrs.	MALE							
	FEMALE							

* ABSENT OR REFUSED. ** NOT REFERRED FOR X-RAY - TO BE RECHECKED IN ONE YEAR.

A SUMMARY REPORT. COMPLETE ONE FORM FOR EACH SCHOOL GRADE SCREENED.
COLORADO DEPARTMENT OF HEALTH, HANDICAPPED CHILDREN'S PROGRAM.

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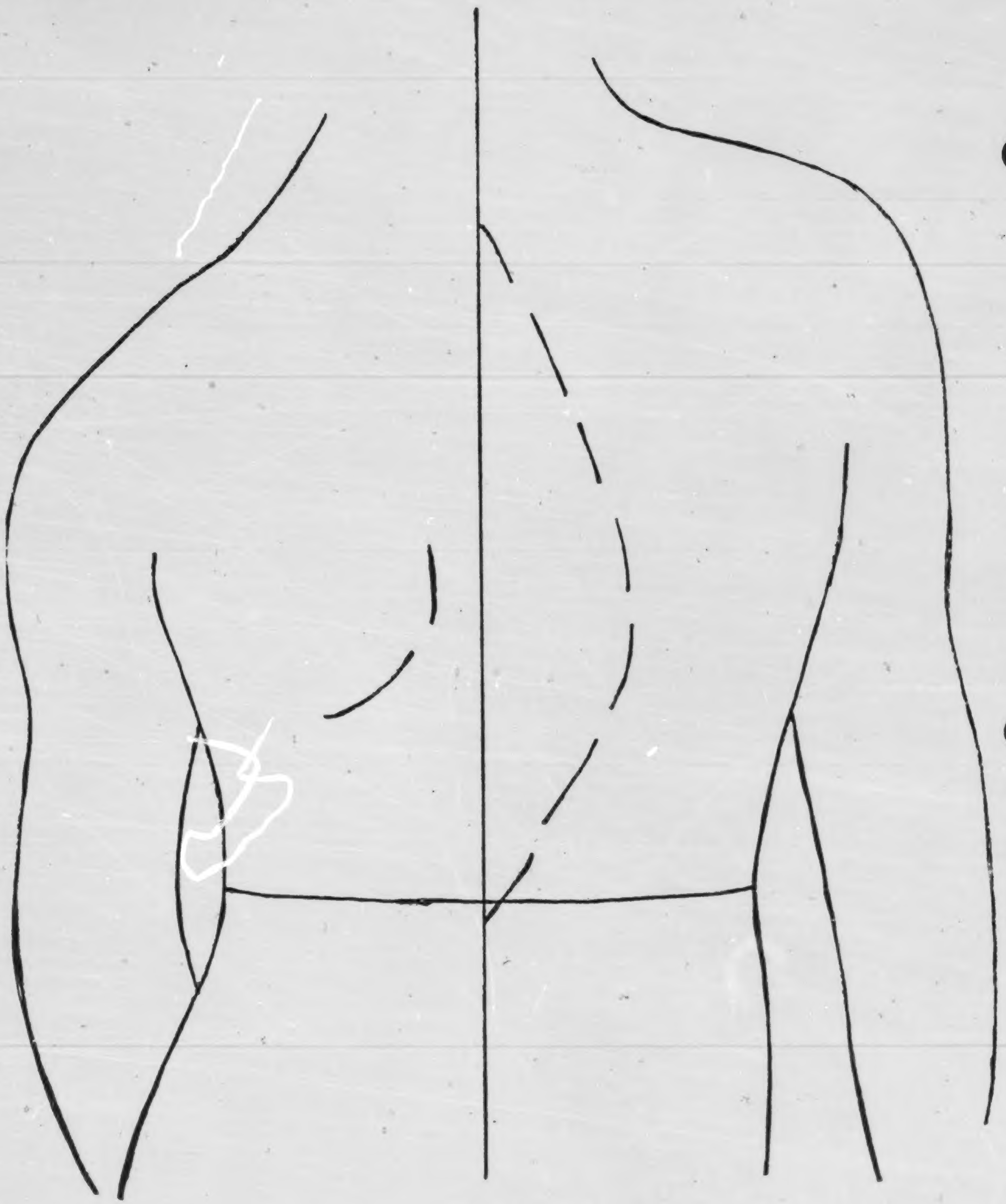
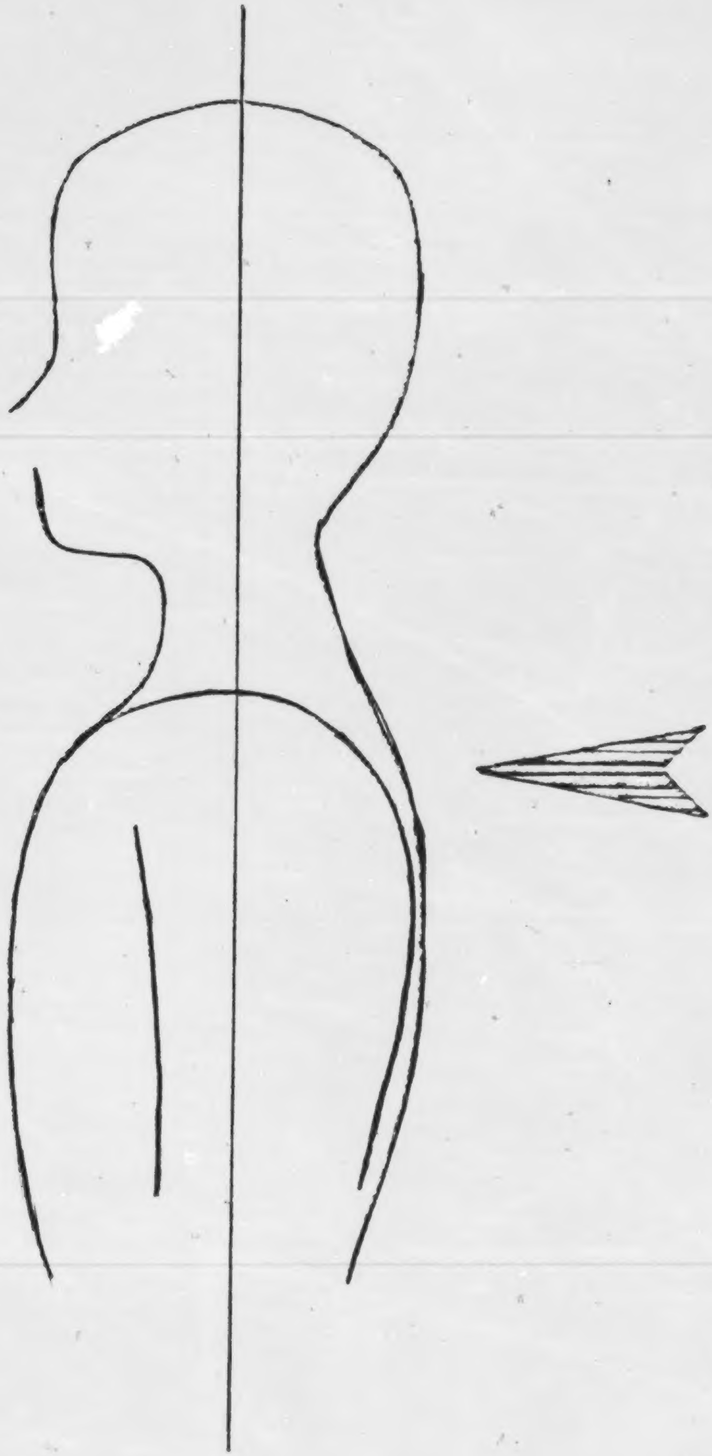


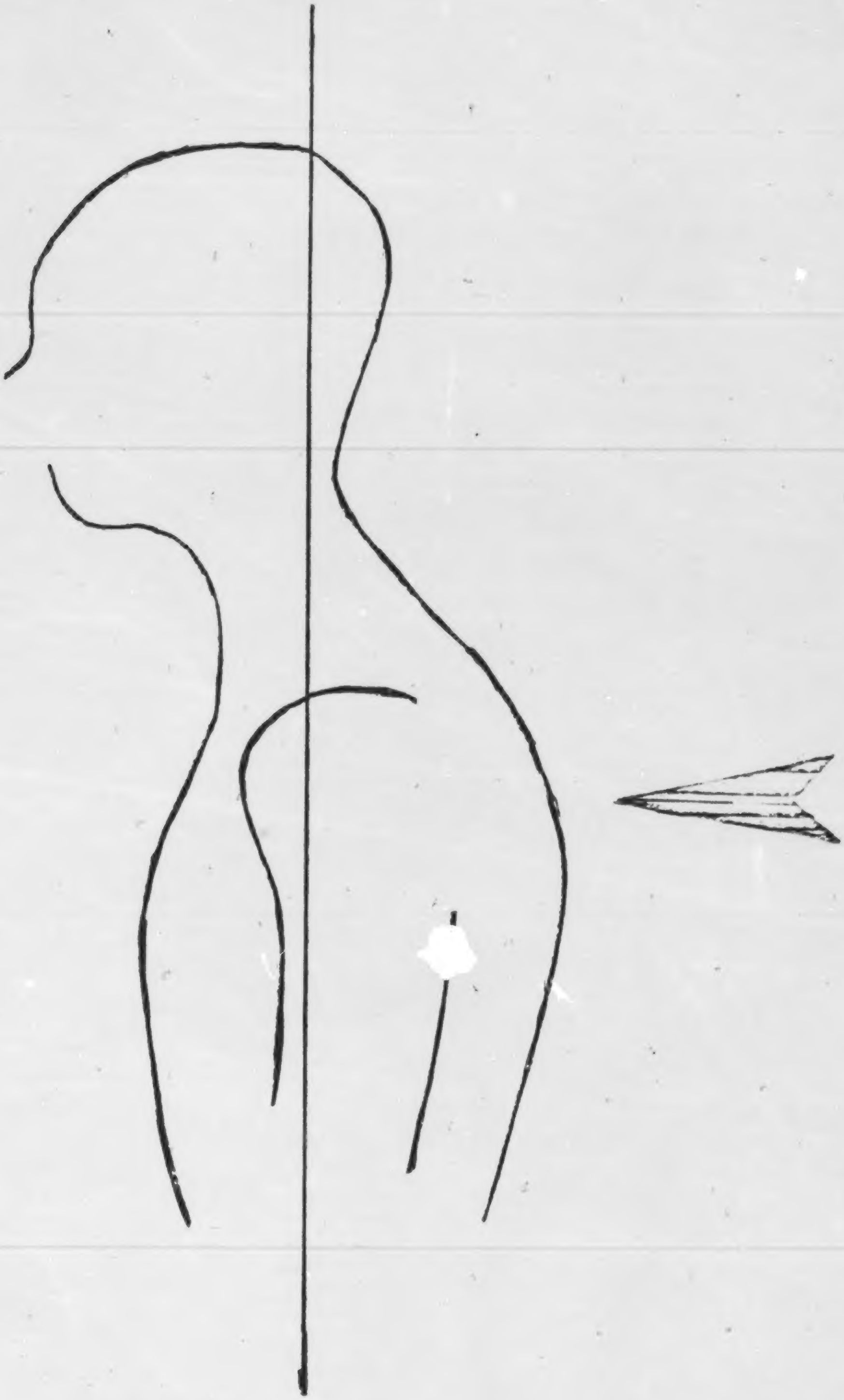
SCOLIOSIS
plate III

SPINE MARKEDLY CURVED LATERALLY



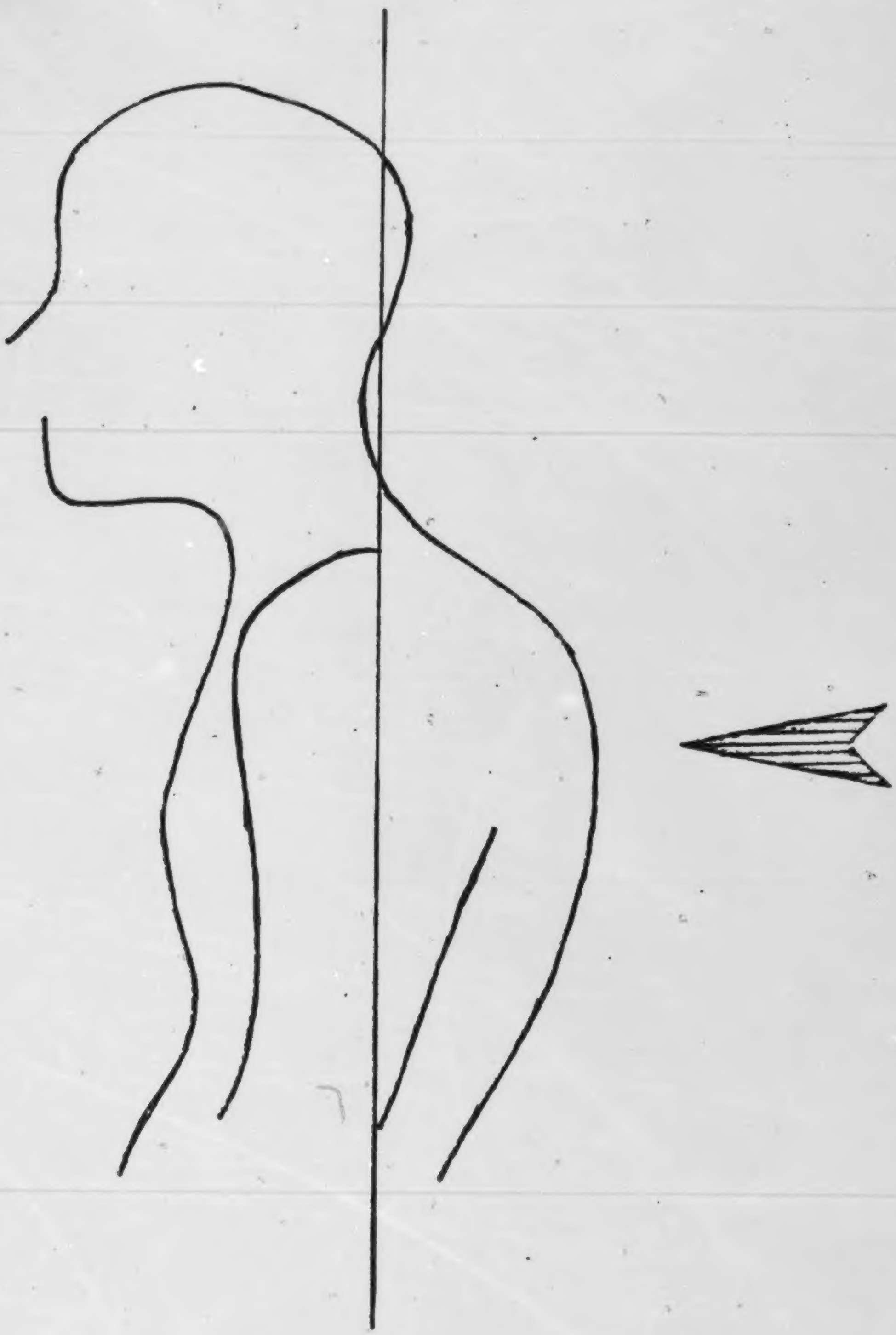
KYPHOSIS
plate I

UPPER BACK NORMALLY ROUNDED, NECK ERECT,
CHIN IN, HEAD IN BALANCE



KYPHOSIS
plate II

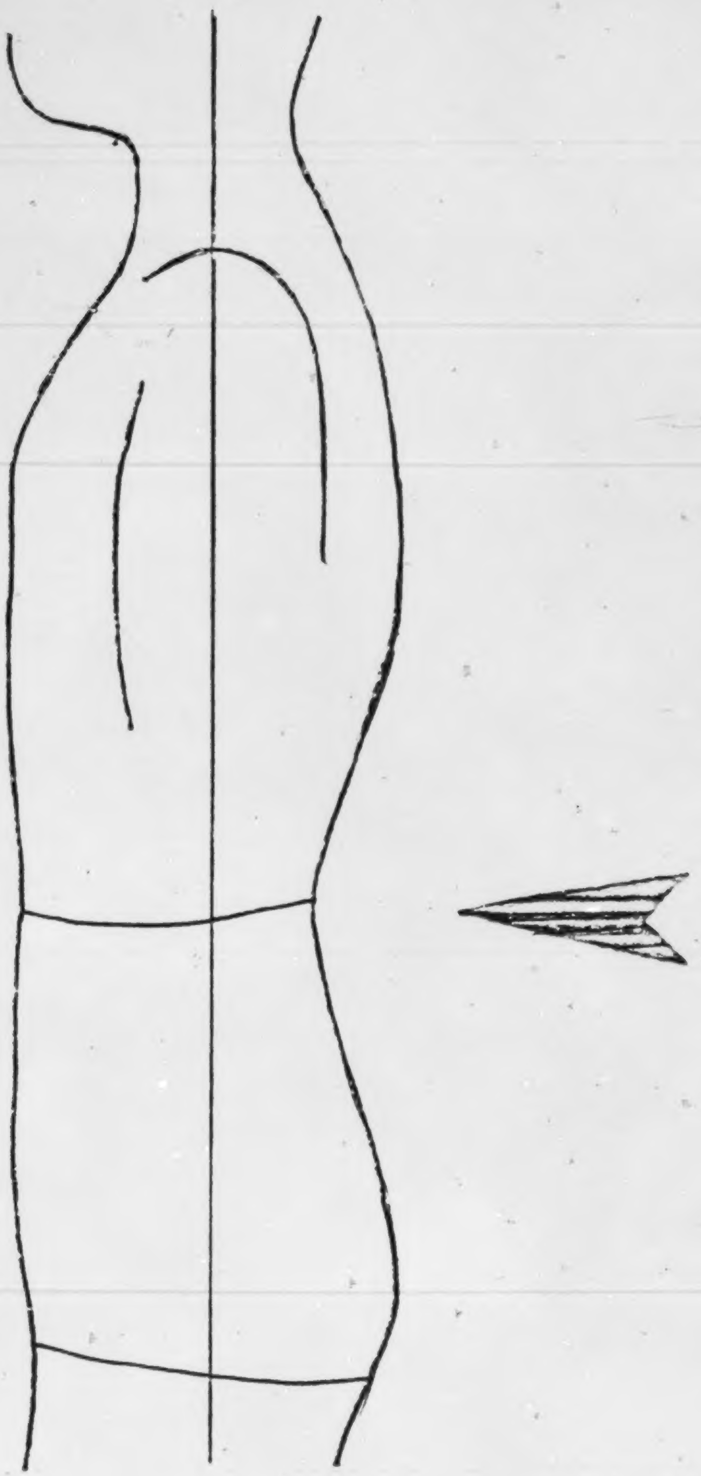
UPPER BACK SLIGHTLY MORE ROUNDED, NECK
SLIGHTLY FORWARD, CHIN SLIGHTLY OUT



KYPHOSIS
plate III

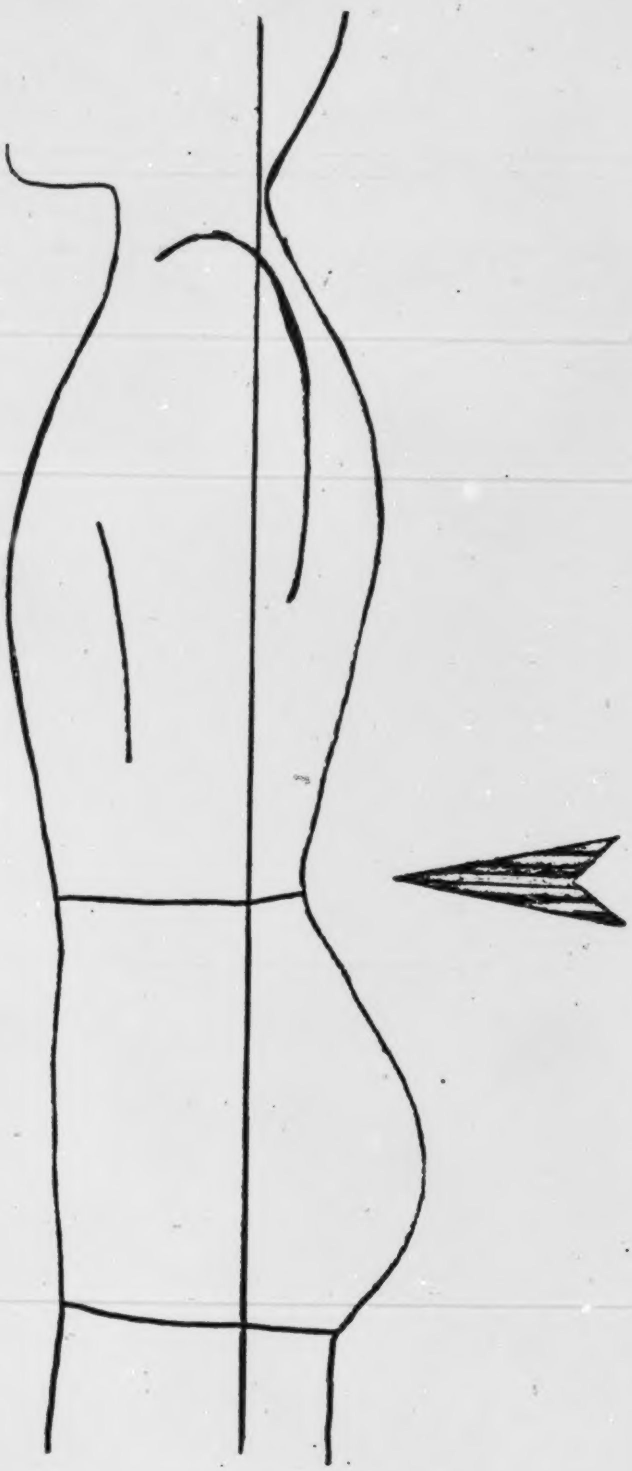
UPPER BACK MARKEDLY ROUNDED,
NECK MARKEDLY FORWARD, CHIN MARKEDLY OUT

100



LORDOSIS
plate I

LOWER BACK NORMALLY CURVED



LORDOSIS
plate II

LOWER BACK SLIGHTLY HOLLOW

SPECIAL REFERENCES AND RESOURCES FOR SCOLIOSIS

PAMPHLETS

"Scoliosis....What's That?" Scoliosis Research Society Suite 800, 430 North Michigan Ave. Chicago, Illinois 60611	Cost: $25 per 100 copies. Minimum order 100 copies. Limited supply available from HCP, Colorado Department of Health
"Scoliosis - Ciba Clinics Symposia" Ciba Pharmaceutical Company Summit, New Jersey	Cost: $1.50 each
"Common Orthopedic Conditions in Childhood" Ross Roundtable Report - 1973 Ross Laboratories Columbus, Ohio 43216	Cost: Free - obtained from local Ross representative
"Brace Yourself - Scoliosis and the Milwaukee Brace" Rainbow Youth Spine Center 2065 Adelbert Road Cleveland, Ohio 44106	Cost: $1.50 each
"What If You Need an Operation for Scoliosis" Rainbow Youth Spine Center 2065 Adelbert Road Cleveland, Ohio 44106	Cost: $1.50 each
"Slow - Dangerous Curve" Scoliosis and Posture-Screening Booklet Wisconsin Department of Public Instruction 126 Langdon Street Milwaukee, Wisconsin 53702	Cost. $1.50 each

FILMS

Scoliosis Screening for Early Detection in a School Program

Color, sound, 14 minutes, 16 mm; Recommended by the Twin Cities Scoliosis Center, Minneapolis, Minnesota. May be borrowed from Colorado Department of Health. Also available from Children's Hospital Orthopedic Clinic.

Dangerous Curve

A film on scoliosis. Public Relations Department, Newington Children's Hospital, 181 East Cedar Street., Newington, Conn. 86111. May be borrowed from Colorado Department of Health.

TUBERCULIN TESTING

Who is to be screened?

1. Testing depends on risk of exposure and tuberculosis prevalence in population group.
2. Preschool (Kindergarten) and adolescent (7th grade) testing is recommended in the following circumstances. In schools with school enterer reactor rate above 1%, skin test school enterers annually. In schools reliably proven to have reactor rates below 1% (at least 85% of enterers tested in previous years), skin test Kindergarten and 7th grade students every 3-4 years to document low reactor rate.
3. Test school employees at employment. If employee has a known positive reaction, chest X-ray and certification of noninfectiousness should be required.
4. The PPD Mantoux test should be used instead of Tine when testing contacts of known diagnosed cases. CAUTION: Do not skin test persons with known positive reactions.

Special alerts

- Fatigue and malaise
- Weight loss
- Cough, with or without expectoration
- Low-grade fever
- Poor appetite

Necessary equipment

- Tine test
- Alcohol or acetone or soap and water
- Cotton balls

Procedure

1. Site: The volar surface of the upper one-third of the forearm, over a muscle belly, is the preferred site.
2. Alcohol, acetone, or soap and water may be used to cleanse the skin. The area must be clean and thoroughly dry before application of the Tine test.
3. Expose the four impregnated tines by removing the protective cap while holding the plastic handle. Grasp the patient's foream firmly, since the sharp momentary sting may cause the patient to jerk his arm, resulting in scratching. Stretch the skin of the forearm tightly and apply the disc with the other hand. HOLD APPROXIMATELY ONE SECOND before withdrawing.
4. Sufficient pressure should be exerted so that the four puncture sites, and a circular depression of the skin from the plastic base are visible. Local care of the skin is not necessary.

Scoring and recording test results

1. Tests should be read at 48-72 hours.
2. Extent is induration is the sole criterion; erythema without induration is without significance. Readings should be made in a good light with the forearm slightly flexed.
3. The size of the induration in millimeters should be determined by inspection and by palpation with gentle finger stroking. Identification of the application site is usually easy because of the distinct 4-point pattern.
4. The diameter of the largest single reaction around one of the puncture sites should be measured. With pronounced reactions the areas of induration around puncture sites may coalesce.
5. Confirm positives greater than 2 mm. with PPD Mantoux test on the opposite forearm (except those which vesiculate).

When you refer

Refer all confirmed positive results.

Incidence

Year	Population Colorado	Colorado Cases	Colorado Rates*	USA Cases	USA Rates*
1970	2,127,676	231	10.9	37,137	18.3
1971	2,207,259	272	12.3	35,217	17.1
1972	2,363,008	248	10.5	32,882	15.8
1973	2,490,102	209	8.4	30,998	14.8
1974	2,584,383	188	7.3	30,122	14.2
1975	2,678,664	220	8.2	33,554	15.7

*All case rates are per 100,000 population.

Referral resources

Family doctor
Local public health agency
TB Control Section, Colorado Department of Health

Because of the low incidence of TB in Colorado the choice of referral is through a specialized public health TB clinic.

Significance of preventive care

A TB skin test can identify possible cases much earlier than a chest X-ray. When tests are positive, INH chemoprophylaxis should be offered. In lieu of INH, annual chest X-rays should be done.

THROAT CULTURE SCREENING

Who may be screened?

Any student who is symptomatic of a strep throat.

Special alerts

Sore throat
Pus in throat
Red throat
Combination of fever, headache, and abdominal pain
Rash
Swollen glands
Suspected skin lesions (impetigo)

Equipment necessary (for the type of testing done by the Colorado Department of Health)

Adequate lighting
Tongue blade
Sterile dacron swab)
Glassine bag)
Lab slip)
Envelope)

Supplied by the Colorado Department of Health and some local health departments to some school districts. Other districts use their own supplies and procedures.

Procedure

1. Open package, remove sterile swab, discard the original swab envelope.
2. Place tongue blade on tongue so that you have a good view of throat.
3. Insert swab to back of throat, taking care that you do not touch the inside of the mouth (or tongue in front of the throat).
4. Roll or rub the swab on one pillar, across the back of throat, especially behind uvula, and on the other pillar, making sure that you get a gag reflex in the process.
5. Remove the swab without touching any other area in the mouth.
6. Let swab air dry. DRYING OF THE SWAB IS CRITICALLY IMPORTANT.
7. While swab is drying, fill out the necessary information on the lab form.
8. When swab is dry, place in glassine bag.
9. Staple (with one staple only) the glassine bag to the left end of lab form and put in mailing envelope. (Seven cultures may be mailed in one envelope for one first class stamp.)

Scoring and recording test results

The local health department or Colorado Department of Health strep lab will notify you of the results. This information should be recorded on the patient's chart.

When to refer

All positive reports should be referred for care. Penicillin is the treatment of choice. Children should be excluded from school until on medication.

Incidence

Routine - Mass culturing programs in schools to detect streptoccal infections are unnecessary because of Colorado's low, and declining, incident of acute rheumatic fever. During March, April, and May of 1975, a surveillance program was conducted to determine the number of acute rheumatic fever cases resulting from strep infections. During those three months, 11,355 strep infections were identified, but only 17 suspected cases of rheumatic fever were reported, of which only 9 were confirmed.

Referral resources

Family doctor and public health clinic.

Significance of preventive care

The identification and treatment of a group A Beta Hemolytic strep throat can prevent scarlet fever, rheumatic fever, and nephritis.

TEMPERATURE

Who is to be screened?

All students who present signs or symptoms that indicate the need.

Special alerts

- Student who has been afebrile with a cold, then has a fever three or four days later.
- Signs of dehydration (thirst, scant urine, skin, tongue or eyes looking dry).
- Mild ear discomfort with temperature over 101° for 24 hours.
- Fever of 101° to 102° F for three days, without explanation.
- Low grade but unexplained fever for five days.

What conditions are necessary?

No special requirements.

Necessary equipment

- oral thermometer
- rectal thermometer
- soap and water
- cotton ball, gauze or paper towel

Procedure

A. Oral temperature
- Shake thermometer down to 96° F
- Insert tip about 1 inch under tongue
- Close lips and leave in 3-5 minutes
- Remove, wipe and read.
- Wash with soap and cold water.

B. Rectal temperature
- Shake thermometer down to 96° F.
- Apply vaseline to tip.
- Insert in anus 1 - 1-1/2 inches
- Leave for 3 minutes
- Remove, wipe and read
- Wash with soap and cold water

C. Axillary temperature (least reliable procedure)
- Prepare thermometer as in oral temperature
- Place under the arm so that it is between the skin of the body and the under arm.
- Leave in place for 10 minutes.
- Remove and read.
- Wash with soap and cold water.

Keep thermometer in a special container of germicide sterilizing solution. Follow directions on the concentrate for diluting to use as a germicide. Keep container out of reach of children since the solution is poison. Do not use a thermometer from the container within five minutes after returning a used one in the container.

Scoring, recording and interpreting

Record the temperature, noting whether it was oral (O), rectal (R), or axillary (Ax).

Average normals are: Oral 98.6 - Rectal 99.6 - Axillary 97.6.

Significance of preventive care

Fever of obscure origin may be associated with infectious diseases, certain disorders of the central nervous system, certain blood and neoplastic diseases, hypersensitization, dehydration, biliary obstruction, certain tumors, heptocellular damage (including infection, poison ingestion), others.

BLOOD PRESSURE SCREENING

Who may be screened?

All students who present signs or symptoms that indicate the need. It should also be taken whenever a routine physical examination is done.

Special alerts

- Headaches
- Dizziness
- Fatigue
- Shortness of breath
- Edema

Necessary equipment

Sphygmomanometer

- The cuff must be the correct width for the diameter of the patient's arm; too narrow - erroneously high reading, too wide - erroneously low reading.

- As a general rule, the cuff should be 20% wider than the diameter of the arm. The diameter of the arm and not the age of the patient determines whether a children's cuff or adult cuff is used.

Stethoscope

- Patient should be comfortable. Position and arm should be specified. The pressure varies with body position, most commonly being higher in the lying position with a slight fall on standing--but in some hypertensive patients, the blood pressure is higher when standing than in the supine position.

- Choice of arm - initially in both arms, then subsequently in the arm found to have the higher pressure.

- Application of cuff - firmly and neatly applied with lower margin about an inch above the anticubital space.

- Preliminary palpation - brachial or radial artery should always be palpated while inflating the cuff. The point at which the pulse can no longer be felt gives the examiner an estimate of the maximal pressure to which the system needs to be elevated in subsequent determinations.

- Deflation - the pressure is raised approximately 30 mm Hg above the point at which the radial pulse disappears and then released at a rate of 2-3 mm Hg per second. (A faster rate of release can result in under estimation of systolic blood pressure and over estimation if diastolic pressure.)

- Korotkoff sounds

Phase I: The period marked by the first appearance of faint, clear tapping sounds which gradually increase in intensity.

Phase II: The period during which a murmur of swishing quality is heard.

Phase III: The period during which sounds are crisper and increase in intensity.

Phase IV: The period marked by the distinct, abrupt muffling sound so that a soft, blowing quality is heard.

Phase V: The point at which sounds disappear.

  - Systolic pressure is the point at which the initial tapping is heard, Phase I.

  - Diastolic pressure, as officially recommended by the American Heart Association, is Phase IV, or the onset of the muffling sound. However, Phase V should also be recorded, e.g. 120/80/72.

Scoring and recording test results

Indicate position, arm and reading

L	(lying)	R.A.	(right arm)
St	(standing)	L.A.	(left arm)
Si	(sitting)		

When to refer

Normal blood pressure for various ages of children:

Ages	Mean Systolic ± 2 S.D.	Mean Diastolic ± 2 S.D.*
Newborn	80 ± 16	46 ± 16
6 months-1	89 ± 29	60 ± 10*
1 year	96 ± 30	66 ± 25*
2 years	99 ± 25	64 ± 25*
3 years	100 ± 25	67 ± 23*
4 years	99 ± 20	65 ± 20*
5-6 years	94 ± 14	55 ± 9
6-7 years	100 ± 15	56 ± 8
8-9 years	105 ± 16	57 ± 9
9-10 years	107 ± 16	57 ± 9
10-11 years	111 ± 17	58 ± 10
11-12 years	113 ± 18	59 ± 10
12-13 years	115 ± 19	59 ± 10
13-14 years	118 ± 19	60 ± 10

*In this table the point of muffling was taken as diastolic pressure. (The source of this table is on the following page.)

Source: R. J. Haggerty, M.W. Maroney, and A. S. Nadas, "Essential Hypertension in Infancy and Childhood," A.M.A.J. Dis. Child. 92:536, 1956. Copyright 1973, American Medical Association.

For adults a referral should be made if the systolic is over 140, or the diastolic is over 90.

Incidence

15-20% of adults in Colorado have sustained high blood pressure. This translates to approximately 200,000 Coloradoans with a health problem and less than half of them are aware of it.

Referral resources

Family doctor
Colorado Heart Association
Public Health Clinic

Significance of preventive care

Early identification followed by successful treatment may prevent heart disease, stroke, and kidney failure. Also, early identification may indicate the presence of a serious health condition such as a brain tumor or other major problem for which the student needs further evaluation.

CHAPTER VIII

SCHOOL HEALTH RECORDS AND REPORTS

Individual School Health Record

An ongoing individual school health record for every student in the school should be an essential part of every school health program. This individual school health record should be designed to bring together in as concise a manner as possible all pertinent information regarding the pupil's health. It should contain significant facts from the students health history, reports of teachers' and others' observations, results of screening tests, and the findings of professional examinations. Also included should be recommendations for treatment and follow-up and subsequent action or plans.

The health record should be easily accessible to school personnel, especially the school nurse. This health rec[illegible] should also accompany the pupil as he progresses through the grades. A folder is a very useful type of health record because additional sheets can be filed inside and become part of this permanent record - such as physical exams, vision evaluations, audiograms, physician's orders for medications at school, certificates of immunization, etc.

For easy identification of students with special health problems, the health record should be tagged. This can be done various ways. It might be designating one color for all health problems, or color coded to indicate different types of health problems. One could use stick-on tapes, stapled on colored paper, or plastic slip-on tags. However, the last type many times gets knocked off.

It should be remembered that confidentiality of medical records applies to school health records. A parental release of information needs to be obtained before the school health records can be shared with another agency or sent to another school district when the student transfers.

Due to the open records law the school nurse should be careful to record objective observations and information, rather than her subjective feel ings or assumptions. However, failure to record a health incident is as wrong as to record a subjective interpretation.

The school health record should be considered part of the student's cumulative record and should be filed as part of that record when the student transfers, withdraws, or graduates. For the school's own protection as to what did or did not happen to the student healthwise while he was in school, this health record should be kept on file for as long as the cumulative record is kept.

Exhibit XXI contains an example of what information should be on individual school health records and shows it as used on a folder.

Exhibit XXII contains policies regarding confidentiality and accuracy of students' records, including the health records.

OTHER FORMS USED IN SCHOOL HEALTH PROGRAMS

The following pages contain some examples of types of forms that are being used in school health programs around the state. These forms are not printed at the Colorado Department of Health, but the school nurses in the districts represented have given their permission for any of the forms to be reproduced by school nurses wanting to use them.

Example A

"Prescription Medications Given at School" this form can be used to keep a record of the students who take prescription medications at school. This type of record is required by the Standards and Regulations for School Environment.

Example B

"Teacher Notification of Student's Health Status" may be used at the secondary level where student has several teachers and changes teachers at the semester.

Example C

"Medication Monitor" may be used for the purpose of improving the feedback between school personnel and doctors when some type of medication is being used to influence a child's behavior at school.

Example D

"Permission for Aspirin" - IF school district policy allows the school nurse to give aspirin or Mydol at school, there should be written permission from the parent. This form is used by one school district and is sent home every fall with every student at the secondary level. Then the medication is given only to those students returning the signed slip.

Example E

"Physical Education Restriction" may be used by the school nurse to send the P.E. teacher a notice of recommended changes in the student's P.E. program.

Example F

"Nurses Report to Parent" may be used to notify parent why a student was sent home when someone other than the school nurse is transporting that student home.

Example G

"High Frequency Hearing Loss" explains the cause and preventive measures that may be taken to prevent further loss.

Example H

"Referral to School Nurse From Teacher" used by the teacher to refer students to the nurse and for feedback information to the teacher.

Example I

"Note to Parents" may be used to send information home to a parent when the nurse wants comments back from either the parent or doctor.

Example J

"Class Room Record" is a work sheet that may be used by the nurse for screening programs.

Example K

"Referral for Eye Examination" may be sent home by the nurse and taken to the doctor at the time of exam for his use in returning information to the school.

Example L

"Health Room Report" may be used to record students who came to the health office and what was done for them. It may be used by the nurse, the health assistant, or the school secretary.

Example M

A "Multi-Referral Form" may be used by a school district which wants to print only one type of referral form, or when a student has multi-problems and a conference is requested with the parent by the school nurse.

Example N

"Emergency Call Card" is information every school district should have on all of the students. It should be available to other school personnel when the school nurse is not in the building.

Example O

"Report of School Dental Inspection" may be sent home by the nurse following dental screening.

Example P

"Guide for Teacher Referral to Nurse" may be distributed to teachers each fall to use as a reference in the type of health problem to refer to the school nurse.

Example Q

"School Weekly Communicable Disease Report" has been used by some school districts to report and keep a record of the number of cases of communicable diseases known to the school district. Responsibility for schools reporting communicable disease is discussed in Chapter IV.

Chapter R

"Permission to Release Information" may be used to release information pertinent to the school program. Samples are shown for release to and from the school.

PRESCRIPTION MEDICATIONS GIVEN AT SCHOOL

	WEEK OF					WEEK OF					WEEK OF					WEEK OF				
SCHOOL	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				
STUDENT MED. ____ DOSAGE ____ TIMES ____																				
STUDENT ____ MED. ____ DOSAGE ____ TIMES ____																				

The person assisting with the medication signs their name in the block under the corresponding day of the week.

EXAMPLE B

SCHOOL HEALTH PROGRAM
TEACHER NOTIFICATION OF STUDENT'S HEALTH STATUS

______________________________, who is enrolled in uour class, has a health problem:
(Name)

____

____

____

____

____

GRADE ____ FIRST SEMESTER: PLEASE INITIAL BELOW AND PASS TO THE NEXT TEACHER.

TEACHER	CLASS	INITIAL

GRADE ____ SECOND SEMESTER: PLEASE INITIAL BELOW AND PASS TO THE NEXT TEACHER.

TEACHER	CLASS	INITIAL

IF YOU HAVE QUESTIONS REGARDING THIS, PLEASE ASK ME FOR FURTHER INFORMATION. WHEN ALL HAVE SIGNED, RETURN TO MY MAILBOX.

____
(School Nurse)

EXAMPLE C

MEDICATION MONITOR

SCHOOL PROGRESS REPORT

Doctor ______________________________

Child's Name ______________________________

Teacher's Name ______________________________

Date of Report (Original / Follow-up) ______________ / ______________

School ______________________________

Please check only the appropriate spaces below. This will help us to understand the situation and to adjust his medication.

	*PRESENT				** AFTER ______ Period of time		
	No Problem	A Little	Quite a Bit	Excessive	Better	Same	Worse
Rowdiness							
Wiggliness							
Out of Seat							
Not attentive:							
to teacher							
to own desk work							
Talks to self							
Talks out of turn							
Irritable							
Crying							
Quiet and withdrawn							
Stubborn							
Belligerent							
		Good	Fair	Poor	Better	Same	Worse
Interest in work							
Follows directions							
Seems content							
Gets along with others							
Reading							
Spelling							
Writing							
Arithmetic							
Concentration							
Large muscle Coordination							
Small muscle Coordination							
Verbal communication							

OTHER COMMENTS:

* Complete and return to doctor immediately.
** Complete after stipulated time and return copy #2 to **designee.**

EXAMPLE D

PERMISSION FOR ASPIRIN

Date ______________________________

____
(Student's Name)

Has my permission to be given aspirin if needed while at school.

Amount? ______________________________

How often? ______________________________

____
(Parent's Signature)

EXAMPLE E

PHYSICAL EDUCATION RESTRICTIONS

Name ______________________________

Condition __________________________

The following P.E. restrictions are recommended:

___ Regular Program ___ No P.E.

___ After School Sports ___ No Contact Sports

___ No Running ___ No Gymnastics

___ No Dressing ___ No Showers

Restricted Activity ___________________

____

Time Limit: Days, beginning ____________

Weeks, beginning ____________

This semester ______________

Requested by ___ Parent ___ Physician ___ Nurse

__________ (date) ____________________ (School Nurse)

EXAMPLE F

NURSE'S REPORT TO PARENT

____

(Student's Name)

Has been sent home by the Community Health Nurse.

Time ______________ Date ______________

Reason ______________________________

____

____

____

____

____

(Nurse's Signature)

HIGH FREQUENCY HEARING LOSS

To the Parents of ______________________: Date__________________________

Many children in Colorado schools have some hearing loss resulting from exposure to loud sounds such as shooting, exploding firecrackers, listening to loud music, driving tractors, driving snowmobiles, working in sawmills, etc. Such hearing loss is permanent, and is not treatable medically or surgically.

In most instances, this type of hearing loss does not interfere with the child's ability to hear and understand speech. However, with continued exposure to these noises through the years, this irreversible hearing loss can progress to a level where the understanding of speech is affected, making it difficult for a person to clearly understand what is being said.

Your child's hearing has been tested and found to be well within normal limits for the speech range. However, there is some evidence of depression of hearing at tones immediately above the speech range. This characteristic is frequently related to noise exposure.

It is very important to protect your child's ears from exposure to loud sounds. Ear plugs designed for protection against noise should be worn at all times in the presence of excessive noises. Such plugs are inexpensive and are available through your local drug store.

____
School Nurse

____
School

EXAMPLE H

REFERRAL TO SCHOOL NURSE FROM TEACHER

Name of teacher ______________________ Date ____________ Room ______

____

____

Child's Name	Reason for Referral	Nurse's Findings

NOTE TO PARENTS

SCHOOL HEALTH PROGRAM

School ______________________________ Date ____________

Name of Child ____________________________ Grade ______

Name of Teacher ______________________________________

Dear Parent:

In watching the health of your child, the teacher and I have noted the following observations which we feel should be brought to your attention:

____

____

____

____

____

Principal Nurse Phone

The school would appreciate comments from you or your doctor regarding these signs if you feel the information would be helpful for the nurse or teacher.

Date ________________

Parent's comments OR Doctor's diagnosis, treatment and recommendations:

____

____

____

____

____

____

____

Parent's Signature OR Doctor's Signature

EXAMPLE J

CLASS ROOM RECORD - (Work Sheet for School Nurse)

Teacher ______________________________

ROOM

Date

NAMES	VISION							HEARING							
	Both Eyes	Without Glasses		With Glasses		Recheck				Recheck		Date Referred	Date Ref. Ret.	Comments - Follow-up
		Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt	Lt			

EXAMPLE K

SCHOOL HEALTH PROGRAM

Referral for Eye Examination

Date ____________ School ______________________ Teacher __________________

To the Parents of ______________________________ Age _______ Grade _______

Your child's visual condition was examined during a recent screening, and we feel it is advisable for your child to have a thorough professional eye examination. Please take this notice to your eye doctor and, after the examination, return this form to your child's teacher with the doctor's signature.

No screening program can take the place of a thorough eye examination, and it may be that the results of this survey may be incorrect as far as your child is concerned. However, since your child did not pass the tests, we strongly advise you to have your child's eyes examined. If your child receives notice of visual troubles and is under treatment for his or her eyes, please indicate this treatment and return this form to the child's teacher.

______________________ ______________________ ______________
Principal Nurse Phone

DOCTOR'S REPORT

Visual acuity uncorrected: R-20/ L-20/ Corrected: R-20/ L-20/

Diagnosis or exaplanation of eye condition: ______________________________

Treatment: Glasses: Yes ____ No ____ To be worn: Constantly ____________

Close work only ____________________ Other ____________________

Other recommendations: ______________________________

When should this child be reexamined? ______________________________

Signed ______________________________
(doctor's signature)
Address ______________________________
Date ______________________________

EXAMPLE L

HEALTH ROOM REPORT ON PUPIL CONTACTS

	TIME		NAME														
DATE	IN	OUT	LAST	FIRST	Back to class	First Aid	Temperature	Conference	Rested	Telephone Call	Sent Home	Parent Came	Nurse Took Home	Referred Doctor	Vision Screened	Hearing Test	REASON

A MULTIREFERRAL FORM

SCHOOL HEALTH PROGRAM

Date ____________________

To the Parent or Guardian of ______________________________
(last name) (first name)

____
(school) (grade)

We recommend that you contact your family physician or dentist regarding these conditions:

____ Audiometric Tests show probable loss of hearing.

____ Eye Tests indicate probable vision difficulty.

____ Teeth Inspection indicates probable need for dental care.

____ Other ______________________________

____

Please come and talk to me at ____________________ School,

at ________ o'clock, on ______________ regarding your child.

Signed ______________________________
School Nurse

Please return this note telling us what has been done or when child

recovered. ______________________________

____

____

____

Date ____________________ Signed ______________________________
Parent

EXAMPLE N

(front side of card)

EMERGENCY CALL CARD

Date ____________________
School ____________________
Grade ____________________
Birth Date ________________

Student's
Name ____ ___
Last First Middle

Address ____ Home Telephone ______________
City ________________________ Zip __________

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information:

EMERGENCY CALLS	Name	Business Address	Business Telephone
Mother			
Father			

If not available, who else may we call for help? Other (1) ____________________

Phone ________, (2) ______________ Ph. __________, (3) ______________ Ph. ________.

Health information: List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems, or any chronic condition, etc.

Explanation: ____
____

DOCTOR
1st choice ____________________ 2nd choice ____________________
Phone number ____________________ Phone number ____________________

**IMPORTANT---PLEASE COMPLETE REVERSE SIDE OF CARD

(back side of card)

I, the undersigned, do hereby authorize officials of ____________________ School District to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

____________________________ ____________________________
Signature of Parent or Guardian

____
Student's Last Name First Initial

EXAMPLE O

REPORT OF SCHOOL DENTAL INSPECTION

Student's Name ______________________ Grade ____ Teacher ________________

Dear Parent, or Guardian:

A school dental inspection has been made. The inspection gives a general idea as to the condition of your child's teeth, but does not take the place of a thorough examination in your dentist's office.

As a result of this inspection we wish to:

____ Commend you for the dental care that has been provided and urge that it be continued.

____ Inform you of the need for dental attention.

____ Urge immediate dental attention. Ill health, pain, and increasing expense can be avoided by prompt dental treatment.

Please check one of the following statements and return the lower part of this sheet to school.

Thank you,

____
School Nurse

- -

Student's Name ______________________ Grade ______ Teacher ________________

_____ My child receives regular dental care, and was last seen by the dentist on ________________ (date).

_____ I have made an appointment with a dentist to have the necessary work done.

_____ I will make an appointment to have the needed work done.

_____ I am unable to make the needed appointment.

Comments: ____

____

____

____
Parent's or Guardian's Signature

GUIDE FOR TEACHER'S REFERRAL TO NURSE

EXAMPLE P

It is recommended that the following observations be referred to the nurse:

EYES:
a. Sties or crusted eye lids
b. Inflamed eye lids
c. Crossed eyes
d. Repeated headaches
e. Squinting, frowning or scowling
f. Protruding eyes
g. Watery eyes
h. Rubbing of eyes
i. Twitching of the lids
j. Excessive blinking
k. Holding head to one side
l. Complaints of blurry vision

TEETH AND MOUTH:
a. State of uncleanliness
b. Gross caries
c. Irregular teeth
d. Stained teeth
e. Gum boils
f. Offensive breath
g. Mouth habits such as thumb sucking
h. Complaints of toothache
i. Swollen jaw

HEART:
a. Excessive breathlessness
b. Tires easily
c. Any history of "growing pains"
d. Bluish lips or fingernails
e. Excessive pallor

GROWTH:
a. Failure to gain regularly over 6-month period
b. Unexplained loss in weight
c. Unexplained rapid gain in weight.

EARS:
a. Discharge from ears
b. Earache
c. Failure to hear questions
d. Picking at the ears
e. Turning head to hear
f. Talking in a monotone
g. Inattention
h. Anxious expression
i. Excessive noisiness of child
j. Ringing in ears
k. Dizziness

GLANDS:
a. Enlarged glands at side of neck
b. Enlarged thyroid

GENERAL APPEARANCE & CONDITION
a. Underweight - very thin
b. Overweight - very obese
c. Does not appear well
d. Tires easily
e. Chronic fatigue
f. Nausea or vomiting
g. Faintness or dizziness
h. Chronic menstrual discomfort

POSTURE AND MUSCULATURE:
a. Alignment of shoulders
b. Peculiarity of gait
c. Obvious deformities of any type
d. Alignment of spine on "standing tall"
e. Muscular development
f. Coordination
g. Muscle tone
h. Use of feet in standing and walking

NOSE AND THROAT:
a. Persistent mouth breathing
b. Frequent sore throats
c. Recurrent colds
d. Chronic nasal discharge
e. Frequent nose bleeding
f. Nasal speech
g. Frequent tonsilitis
h. Chronic coughing

ANY CHRONIC ILLNESS (known or suspected diagnosis)
a. Diabetes
b. Epilepsy
c. Rheumatic Fever
d. Cystic Fibrosis
e. Orthopedic condition
f. Severe hearing loss
g. Unremedial visual loss or handicap
h. Other special conditions

OTHER:
a. Students who lack medical care due to financial stress or religious views
b. Known or suspected social, family, financial situations affecting the health of the student
c. Prolonged absenteeism due to illness
d. Homebound students
e. Suspected or known pregnancies
f. Children subjected to physical abuse
g. Children receiving medications for a prolonged time and for chronic conditions
h. Students new to school district

SKIN AND SCALP:
a. Unusual pallor of face
b. Eruptions or rashes
c. Habitual scratching of scalp or skin
d. Nits on the hair
e. State of uncleanliness
f. Excessive redness of face

BEHAVIOR:
a. Over studious, docile withdrawing
b. Bullying, overagressiveness and domineering
c. Unhappy and depressed
d. Overexcitable, uncontrollable emotions
e. Stuttering or other forms of speech difficulty
f. Poor accomplishment in comparison with ability
g. Lying (imaginative or defensive)
h. Lack of appreciation of property rights
i. Abnormal sex behavior
j. Antagonistic, negativistic, continual quareling
k. Excessive use of toilet
l. Enuresis

EXAMPLE Q

SCHOOL WEEKLY COMMUNICABLE DISEASE REPORT

REPORT PERIOD BEGINS ON MONDAY, ENDS ON FRIDAY

DISEASE	WEEK																				
RUBEOLA (Measles)																					
RUBELLA																					
MUMPS																					
CHICKEN POX																					
STREP																					
FOOD-BORNE OUTBREAKS*																					
PEDICULOSIS																					
ANIMAL BITES*																					
HEPATITIS																					
MONONUCLEOSIS																					
OTHER																					

1. Communicable diseases requiring immediate telephone reporting:

MEASLES	PERTUSSIS (whooping cough)
RUBELLA	MENINGOCOCCAL INFECTION
POLIO	GASTRO-ENTERITIS (suggesting group outbreaks)
DIPHTHERIA	

2. Measles and rubella to be tabulated weekly as well as telephoned immediately.

3. Any reportable disease should be telephoned immediately on suspected group outbreak, such as food-borne outbreaks.

4. Report form is in triplicate. On a semester basis, one copy to be forwarded to School Administration Health Office, one copy to County Health Department, one copy retained by school nurse.

*These are not communicable diseases, but are required to be reported by the Colorado Communicable Disease Control Laws and Regulations. See Chapter IV for details.

EXAMPLE R

PERMISSION TO RELEASE INFORMATION

DATE______________________________

SCHOOL____________________________________ ADDRESS______________________________

PRINCIPAL__________________________________

I hereby authorize the _________________________ Schools to release information, including medical reports, concerning________________________________ (name), __________ (birth date) ____ (address) to the ____________________________________ for use by the professional staff as necessary.

SIGNATURE OF CHILD ____ (if ten years of age or older)

SIGNATURE OF PARENT OR LEGAL GUARDIAN ____

RELATIONSHIP ____

STAFF MEMBER WITNESS TO SIGNATURE ____

* * * * * * * * * * * * *

DATE______________________________

I hereby authorize the ____ to release information including medical reports acquired in attending________________________ (name), ________________ (birth date), to the ___________________________ Schools for use by the professional staff as necessary.

SIGNATURE OF CHILD ____ (if ten years of age or older)

SIGNATURE OF PARENT OR LEGAL GUARDIAN ____

RELATIONSHIP ____

STAFF MEMBER WITNESS TO SIGNATURE ____

(School personnel making the referral must obtain signatures on two copies. One copy is to be sent to the referral agency and one copy is to be filed in the student's permanent record folder and never discarded.)

Reports of School Health Programs

It is well-recognized that no one likes paper work - especially statistics. However, for accountability of a school health program statistical data is essential. Statistical data is helpful to reveal work loads and accomplishments and also as an evaluation tool to gauge progress or lack of it; to point out program needs or those needs being met; and to stimulate the future development of long and short range program goals.

Many superintendents and school boards appreciate periodic or special reports of the school health and nursing services being rendered in their districts. These reports are most helpful if they include the statistical data and a narrative section.

The narrative section of the report can include such information as:

1. An overview of significant findings to highlight important health problems.
    - What procedures can be used to attack these problems?
    - How will the findings be used to plan the school health program for the coming year?
2. A description of other school activities.
    - Classes prepared for and taught
    - Health talks given and to whom
    - Health education materials prepared, secured and how used
    - Conferences with faculty regarding their health concerns and/or health education curriculum, resources provided, etc.
3. Continued activities and inservice efforts to improve the health program.
    - Faculty meetings
    - Committee meetings - include kind
    - Health council meetings
    - Self-education
    - Other professional meetings
4. Coordination of school health activities with community activities.
5. Future plans to meet school health needs.

Some uniformity has been attempted in Colorado to have one type of statistical data being collected for school health programs. The public health school nurses do keep a "Daily Report Health Workers' Activity System." This report is computerized and does have a school health component. The school-district-employed school nurses are not part of this computer report system.

The school-district-employed school nurses have developed a variety of statistical reporting systems, with many of the districts not collecting any data at all. Some of these nurses not collecting data have found the need for it when the "budget crunch" hit.

Therefore, on the following pages are examples for school-district-employed nurses of a monthly worksheet, a yearly summary sheet, and the instructions for the use of these. It will not always be necessary to submit these to the Colorado Department of Health each year. School nurses will be informed in the fall of each school year as to the type of data to be collected, and requested by the Colorado Department of Health.

It is hoped that school nurses will see how useful such statistical data is for them and their school districts.

MONTHLY WORK SHEET - NURSING SERVICES TO SCHOOLS

DATE ______________ COUNTY ______________ NURSE ______________
SCHOOL ______________ TYPE ______________ ENROLLMENT ______________
(Elem. Jr. High Sr. High)
HOURS IN SCHOOL ______________ NO. VISITS TO SCHOOL ______________
NO. VISITS TO HOME ______________

	NO. PUPILS CONTACTED	NO. REFERRALS	REFERRALS COMPLETED	
I. HEALTH SUPERVISION			Treated	Overreferred
Health evaluation or counseling				
Acute illness or First Aid				
Child Abuse				
II. PHYSICAL EXAMINATIONS				
By doctor				
By nurse				
III. SCREENING BY NURSE, VOLUNTEER, TEACHER, OTHER				
Vision				
Hearing				
Dental				
Weight & Height				
Throat Cultures				
Nuisance Diseases				
T.B. Skin Testing				
Other (specify)				

IV. OTHER ACTIVITIES	IND. CONFERENCES		GROUP		HEALTH ED.	CLASSES	
	Student	Program	No.	Attendance	Consultation	No.	Attendance
Teacher and Supportive Staff							
Parent							
Student							
Community Group or Person							
Case Conference (multidisciplinary)							

V. ACTIVITIES RELATED TO HANDICAPPED CHILDREN'S EDUCATION ACT (not included above)

	No. Contacted	No. Referred	No. Treated
Health Assessments			

Students Prestaffed		Parents Contacted	
Students Formally Staffed		Contact w/Other Agencies	
Students Annual Review		Teacher or Staff Contacted	

VI. INDIVIDUALIZED SCHOOL DISTRICT ACTIVITIES

CDH Nursing (Rev. 9/76)

Dates Covered ______________________
Type Coverage ______________________
(Elem. or Secondary)

COLORADO DEPARTMENT OF HEALTH
School Nursing Summary Sheet

School District ______________________
County ______________________
Total Enrollment ______________________

Submit two for each school district - one for Elementary and one for Secondary

TOTAL VISITS TO SCHOOL ________
AVERAGE HOURS PER VISIT ________
FTE NO. OF NURSES ________
NO. OF HEALTH AIDES ________
TOTAL NO. OF HOME VISITS ________
TOTAL NO. OF SCHOOLS ________

			TOTAL NO. REFERRALS COMPLETED	
I. HEALTH SUPERVISION	Total No. Pupil Contact	Total No. Referrals	Treated	Overreferral
Health Evaluation and Consultation				
Acute Illness and First Aid				
Child Abuse				
II. PHYSICAL EXAMINATIONS				
By Doctor				
By Nurse				
III. SCREENING BY NURSE OR OTHER				
Vision				
Hearing				
Dental				
Weight and Height				
Throat Cultures				
Nuisance Diseases				
TB Skin Tests				
Other (specify)				

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IV. OTHER ACTIVITIES	Individual Conferences		Group		Health Ed.	Classes	
	Student	Program	No.	Attendance	Consultation	No.	Attendance
Teacher and Supportive Staff							
Parent							
Student							
Community Group or Person							
Case Conference (multidisciplinary)							

V. ACTIVITIES RELATED TO HANDICAPPED CHILDREN'S EDUCATION ACT (not included in above)

	Total No. Pupils Contacted	Total No. Referred	Total Who Received Care
Health Assessments			

Students Prestaffed ______________________
Students Formally Staffed ______________________
Students Annual Review ______________________
Parents Contacted ______________________
Contact With Other Agencies ______________________
Teachers and Staff Contacted ______________________

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VI. INDIVIDUALIZED SCHOOL DISTRICT ACTIVITIES

____

____

201

Please submit by June 15,if requested,to School Health Nursing Consultant, Colorado Department of Health, Nursing Division
4210 E. 11th Ave., Denver, 8022[illegible]

(Rev. 9/7[illegible] CDH Nursing

DIRECTIONS FOR SCHOOL NURSING STATISTICAL REPORT

Instructions for Completing Monthly Work Sheet - Nursing Services to Schools

Date and School: One monthly work sheet should be used for each school a nurse covers.

Hours in School: Those hours the nurse spent on school activities, both in and out of the building.

Number of Visits to School: The number of times in one month a nurse visited a particular school.

Number of Home Visits: The number of home visits the nurse made on behalf of a student, or the school.

Other Introductory Data: Should be self-explanatory.

I. Health Supervision

Health Evaluation or Counseling: Individual student contacts for the purpose of evaluating a student's health problem or counseling regardless of diagnosis (with the exception of child battering). "Number Referrals" includes those students who were referred to doctor, dentist, health clinic, other school personnel for follow-up, or other services which can give the student additional help or care. "Referrals Completed" includes the number of referrals which were evaluated and indicate whether the referral was treated or an overreferral. "Treated" includes those students who received care as a result of the referral, and "overreferral" includes those students who were evaluated but did not need care. This does not include health assessments done for HCEA.

Acute Illness or First Aid: Include the students who are seen primarily for acute illness or First Aid. Fill in number referred for care and treated.

Child Abuse: Include the students seen and evaluated for suspected child battering. Fill in the number who are referred to child welfare or physicians or other agency for follow-up and the number treated.

II. Physical Examinations

Include the number of examinations done at school by doctors, nurse practitioners, or nurses with primary care skills. Physical examination by doctor also includes those exams done in the doctor's office, and then reported to the school. Fill in number referred and treated. This does not include health assessments done for HCEA.

III. Screening by Nurse, Volunteer, Teacher, Other

Include the number of students screened in each category with the number of failures referred and the number who received care, also indicating whether the referral was treated or an overreferral. Nuisance diseases may include pediculosis, ring worm, impetigo, etc. An extra space is provided for any additional screening you might be doing. Please state the type of screening if you use this line. Immunizations should be included under VI. Individualized School District Activities.

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IV. Other Activities: (not related to HCEA)

Individual Conferences: "Student" includes individual student-oriented conferences. "Program" includes program-oriented conferences - may be about a small group of students, a class, or the whole school.

"Teacher and Support Staff" includes any individual conferences with teachers, principals, school social workers, psychologists, audiologists, counselors, secretaries, or other school personnel.

"Parents" includes contacts made in person, or on the telephone.

"Students: includes individual student conferences about himself. The nurse will probably have a limited number of individual conferences where she talks with the student about a program.

"Community Group or Person" includes the welfare workers, service club members, or other community people the nurse may have contact with to assist a student, or discuss a program.

"Case Conference" - not applicable.

Group: Includes groups the nurse works with - not a class she teaches, but a group meeting. Also includes the attendance "Teacher and Support Staff" and faculty meetings, etc.

"Parent" - may include P.T.A. meetings, advisory committee, etc.

"Student" - includes a group counseling or discussion meeting.

"Community Group" could be a mental health board meeting, or school board meeting.

"Case Conference" is the multidisciplinary conference held about a student, or program, but does not include any covered by the Handicapped Children's Educational Act.

Health Education Consultation: Includes the consultation the nurse might give to students, teachers, support staff, parents, or a community group about health education.

Classes: Includes the number of classes the nurse teaches and the attendance. In addition to classes for students, the nurse might conduct an inservice for teachers and staff, or a P.T.A. program for parents, or a community group health program.

V. Activities Related to HCEA

Health Assessments: Those students who have a health assessment done by the nurse for the HCEA. "No. Referred" includes those students that had a health assessment and were referred further for more indepth evaluation or treatment for abnormal findings. "No. Treated" includes the students who completed, or are in the process of following through on the referral.

Students Prestaffed: The number of students discussed in a prestaffing or mini staffing.

Students Formally Staffed: The number of students staffed for placement in a special program.

Students Annual Review: The number of students who are discussed annually for continued placement or removal from a special program.

Parents Contacted: The number of contacts with parents concerning their student(s) in relation to the HCEA.

Contact With Other Agencies: The number of contacts with agencies outside the school who are contacted in relation to student evaluation, or program evaluation, in relation to the HCEA.

Teacher or Staff Contacted: The number of contacts with teachers, or supporting staff, who are contacted for additional information on students, or programs, of HCEA.

VI. Individualized School District Activities

This section was requested by several school districts to record activities which were not listed elsewhere; for example: immunizations and transporting sick children home. It can be used however the individual school district wishes.

Instructions for Completing School Nursing Summary Sheet Form

This sheet is used to summarize the activities recorded on the monthly work sheet. School nurses may wish to summarize the activities monthly for reports to principals, or school boards. The nurse may also wish to add a short narrative report to inform her district of interesting things she did that month.

The only summary the Colorado Department of Health, Nursing Section, will be requiring is an annual summary to be submitted by June 15, or as soon after as possible. It is important that the summary be divided - one summary for elementary level and one summary for secondary level for each school district.

Also "Dates Covered" on this report should indicate the period of time the report covers; for example: September 1976 - June 1977.

"**FTE Number of Nurses**" means the number of full time equivalent school nurses. If a nurse works part time, it should be recorded as a fraction of a FTE; e.g. if a nurse works half time she is .5 FTE, or if she works two days a week she is .4 FTE.

Please mail the annual summary by June 15 to:

School Health Nursing Consultant
Nursing Division
Colorado Department of Health
4210 E. 11th Avenue - #255
Denver, Colo. 80220

if requested in the previous fall by the Colorado Department of Health.

EXHIBIT XXI (side 1)

Tag for
Special
Health
Condition

NAME: ______________________________ (Last (First) (Middle) M ☐ F ☐ DATE OF BIRTH: ______________ (Month) (Day) (Year)

PARENT'S NAME: ______________________________

MEDICAL HISTORY (incl. date)
(Check those which apply & comment below)

ALLERGIES ______
Drug ______
Other ______
ASTHMA ______
CONGENITAL DEFECTS ______
CONVULSIVE DISORDER ______
DIABETES ______
HEARING PROBLEMS ______
HEART CONDITION ______
HIGH BLOOD PRESSURE ______
NEUROLOGIC DISORDER ______
Migraine ______
RHEUMATIC FEVER ______
SURGERIES ______
ULCERS ______
VISUAL PROBLEMS ______
Glasses ______ Yes ______ No ______
ORTHOPEDIC PROBLEMS ______
SERIOUS ACCIDENTS ______
OTHER ______

SCHOOL SCREENING RESULTS

			HEARING			VISION			SCOLIOSIS*				DENTAL**	
GR.	SCHOOL	DATE	R	L	Ref.	R	L	Ref.	P	F	Q	R	RESULTS	Ref.
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							
						20/	20/							

Color Deficiency Passed___ Failed___ Date______
Muscle Imbalance Passed___ Failed___ Date______
Depth Perception Passed___ Failed___ Date______
Speech (Therapy) ______________________________
Physical Therapy ______________________________

*Scoliosis Key
P-Passed
F-Failed
Q-Questionable
Ref. Referred

**Dental Key
1-No Caries
2-Attn. needed
3-Urgent
4-Brush More
5-Orthodonist

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IMMUNIZATION AND TESTS

	DATES			
Oral Polio				
D.T.P.				
D.T.				
Measles				
Rubella				
Mumps				
TB Test				

Religious Exemptions ______
Medical Contraindication ______

PHYSICIAN'S RECOMMENDATIONS, RESTRICTIONS AND MEDICATIONS

	DATES			

COMMENTS ON SPECIAL HEALTH CONDITIONS AND REFERRALS MADE FROM SCREENING PROGRAMS:

____
____
____

(side 2)

CUMULATIVE SCHOOL HEALTH RECORD
TEACHER-NURSE OBSERVATION

	DATE (by year)												
	GRADE												
1 GENERAL CONDITION APPEARANCE	UNDERWEIGHT												
	OVERWEIGHT												
	DOES NOT APPEAR WELL												
	TIRES EASILY												
	POOR MUSCLE COORDINATION												
	BAD POSTURE												
2 BEHAVIOR	EMOTIONAL DISTURBANCES												
	SPEECH DEFECTS												
	TWITCHING MOVEMENTS												
	NERVOUSNESS												
	UNDULY RESTLESS												
	SHYNESS												
	NAIL BITING												
	FREQUENT USE OF TOILET												
3 HEALTH HABITS	GENERAL CLEANLINESS												
	FOOD HABITS												
4 EYES	STYES OR CRUSTED EYES												
	INFLAMED EYES												
	CROSSED EYES												
	FREQUENT HEADACHES												
	READING DIFFICULTY												
	SQUINTS												
5 EARS	DISCHARGE FROM EARS												
	EARACHES												
	POOR HEARING												
6 NOSE AND THROAT	PERSISTENT MOUTH BREATHING												
	FREQUENT SORE THROAT												
	FREQUENT COLDS												
7 ABSENCES FOR ILLNESS	NUMBER DAYS ABSENT												
	COLDS												
	STOMACH, INTESTINAL UPSET												
	OTHER (specify)												
PHYSICAL EDUCATION EXEMPTION													
INITIALS OF SCHOOL NURSE													

Code: ✓ Indicates other than normal.
0 Indicates normal.

All entries to be made under supervision of school nurse.

(side 3)

FURTHER HEALTH INFORMATION

DATE	SUGGESTIONS AND NOTES	SIGNATURE	TITLE

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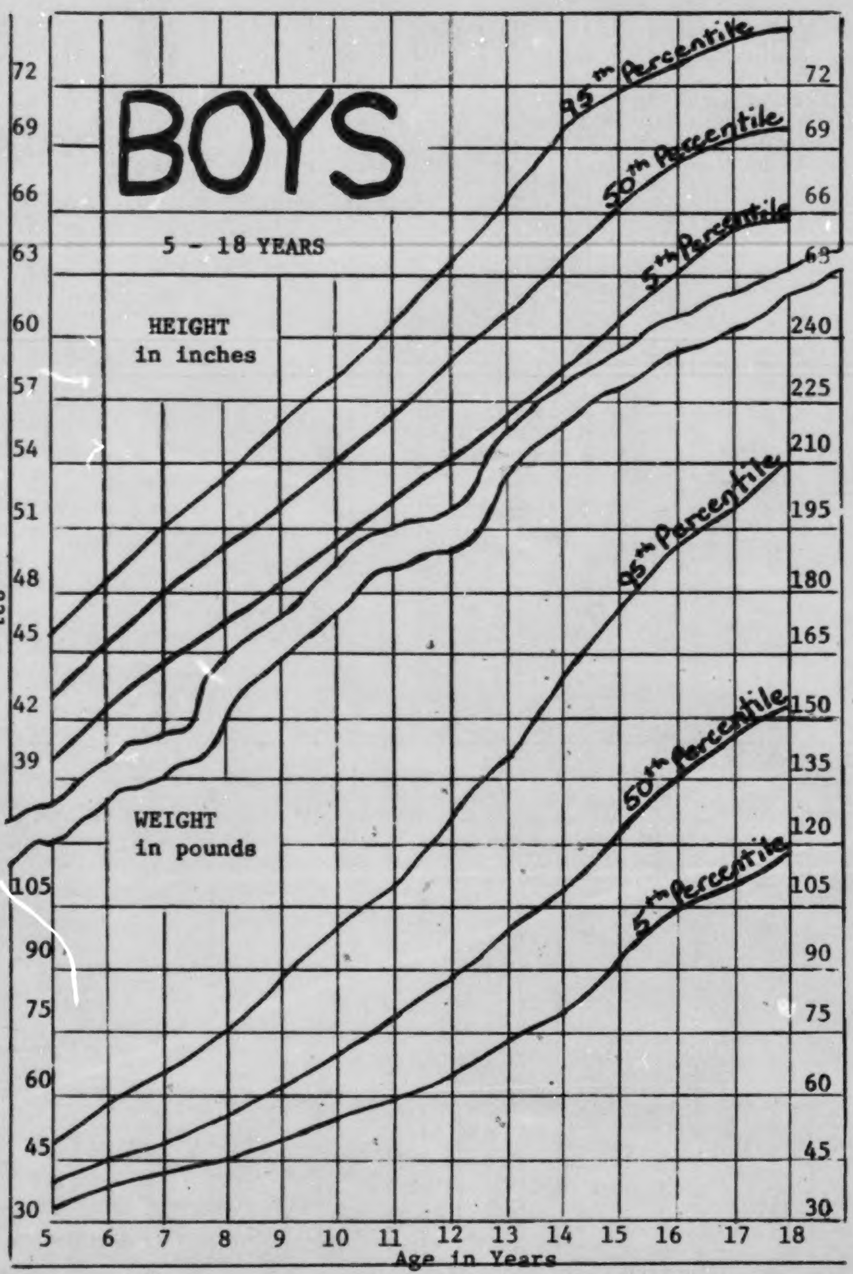

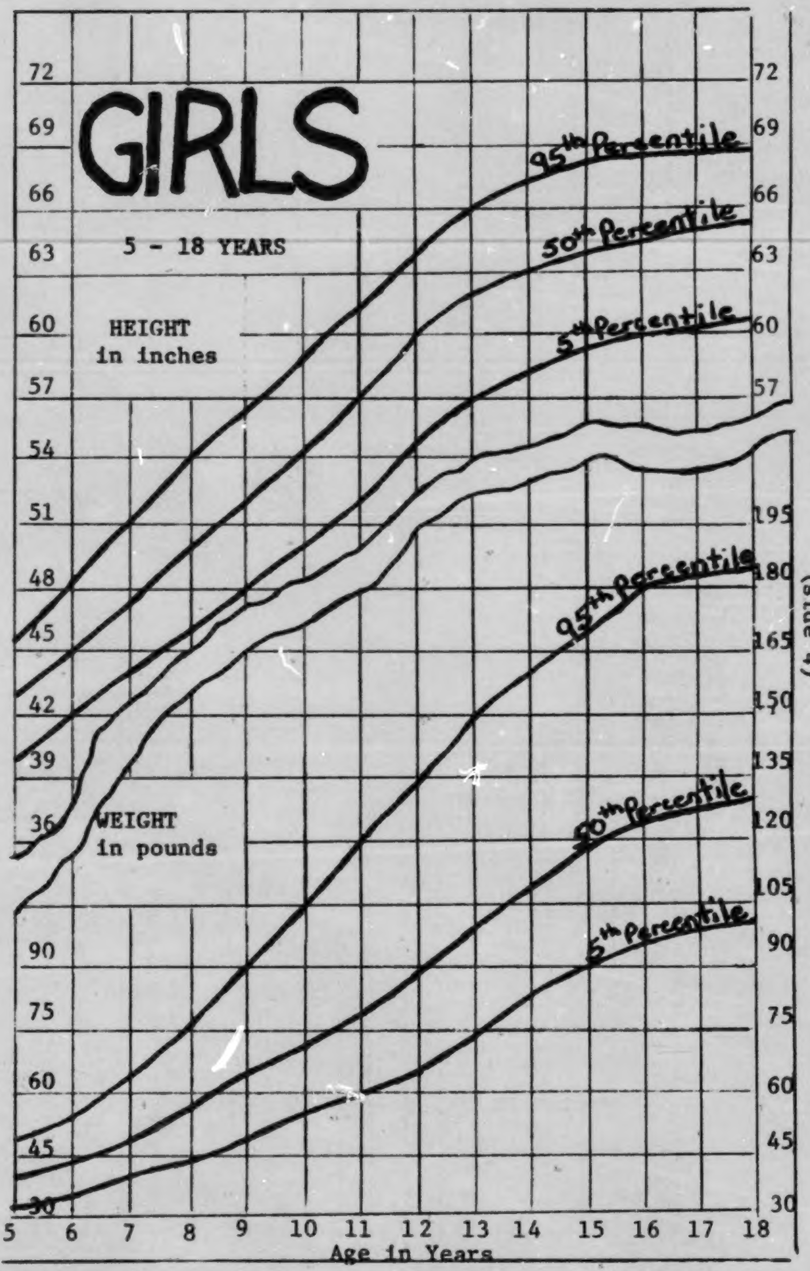

(side 4)

MEASUREMENTS TAKEN FROM 976 HEW RECOMMENDATIONS

EXHIBIT XXII

POLICIES REGARDING CONFIDENTIALITY OF STUDENTS RECORDS

Custody of Records

The public school is the legal custodian of student records. It is responsible for the provision of a safe place for storage of student records to prevent disclosure to persons not concerned with care of the student. Student records should be kept in locked files when not in use and must not be left where other than authorized persons have access to them.

Disclosure of Confidential Information - Conditions and Limitations

1. The Open Records Law

The Colorado General Assembly during its 1968 session passed Senate Bill No. 3, which is commonly referred to as the Open Records Bill. This bill became law July 1, 1968, and an analysis of the general content may provide insight into the importance of maintaining well organized, complete, and objective records.

Medical records are not listed in the exceptions. The law states that the custodian of records (defined as any authorized person having personal custody and control of the public records in question, e.g. the school health nurse) shall deny the right of inspection of medical records except to the "person in interest." The person in interest means and includes the person who is the subject of a record or any representative designated by said person. A parent or duly appointed legal representative will be the person of interest if the subject of the record is under legal disability.

The law further states that either the custodian or person of interest may request a professionally qualified person to be present to interpret records. If in the opinion of the custodian of a public record disclosure of the contents of said record could produce substantial injury to the public interest, he may apply to the district court of the district in which the record is located for an order permitting him to restrict such disclosure.

The foregoing provisions apply to the inspection of records, as contrasted with the release or transmittal of records. The law, however, provides that in all cases in which a person has the right to inspect a public record, he may request that he be furnished copies of such record. The custodian can charge a reasonable fee for this duplication. The custodian may make such rules and regulations with reference to the inspection and duplication of records as shall be reasonably necessary for the protection of such records and the prevention of unnecessary interference with the regular discharge of the duties of the custodian or his office.

2. The Person in Interest

The parent or guardian has the right to free access to the information recorded in the student's record with the limitations as stated in the Open Records Law. The person in interest has the right to assume that the material in the student's record is strictly confidential, and that it will not be shared with other persons or agencies without his informed consent. It is possible to obtain a general release of information consent when the student is being evaluated or admitted for service. This will give permission for the release or receipt of information and reports pertinent to health care between the public school and related professional agencies. The person in interest retains the right to request that he be notified directly of each individual release of information.

3. Other Agencies or Services

Information may be released to other agencies or persons with the written consent of the "person in interest."

Information is not released unless the public school is reasonably sure that:

- The confidential nature of the information will be preserved, and
- Information obtained will be used for the purpose related to the request from the inquiring agency or person and for no other purpose.

Records may be subpoened by the courts.

4. Other Considerations in Maintaining Confidentiality

All persons employed in the public school should be oriented to the importance of safeguarding the confidential nature of the health record and any other student information. Privacy and confidentiality in gathering student information by interview or any other means is essential. Office and clinic facilities should be such that student information is not inadvertently revealed to persons in the office or any place else. Discretion must be used in engaging a student in discussion in his home or on the street while neighbors, relatives, or other persons are present.

CHAPTER IX

EVALUATION OF SCHOOL HEALTH SERVICES

Evaluation of school health services is a continuous process and necessary if the needs of pupils, school personnel, and community are to be met. Evaluation is or should be a learning process. A school district can discover answers to questions such as "How well are we doing?" and "Why?" and "If not, how can we improve?" The evaluation requires asking many related questions and a careful analysis of the relationship of many items of information.

A program must be evaluated for its worth and for its future. Any program revolving around school children is undergoing constant change. More and more, school programs are being required to produce evidence of their effectiveness and efficiency by documenting program achievements.

Some of the benefits to be gained from evaluating the school health services are:

1. Demonstrating contribution nursing service offers to educational programs for students.
2. Stimulating professional interest and desire to improve the program.
3. Comparing the existing program to recommended programs and practices.
4. Improving procedures and practices for detecting defects and for referrals should result in improved health of the children.
5. Identifying community needs for resources to serve school-age children.
6. Sharing the results of the evaluation with involved school personnel and community groups, such as the School Health Council, other committees and parents so there can be a joint effort to improve the school health services program.

There are many evaluation forms printed for use in evaluating a school health service. The National Education Association, Department of School Nurses has printed Standards for School Nurse Services, and Evaluation Instruments for School Nursing Service for use in program evaluation.

In Colorado, the high school evaluations done for accreditation use the North Central Accreditation Evaluative Criteria. This evaluation criteria does include one page on school health services. Most high school principals or the school superintendent have a copy of these evaluation criteria.

In Exhibit XXIII there is a sample form - Guidelines for Evaluation of School Health Services. This guideline incorporates the ideas from many evaluation tools. Sections II and III of this manual will include guidelines for evaluating those parts of the total school health program.

Since vision and hearing screening are mandatory by law, Exhibit XXIII also has a sample of guidelines for evaluating those programs.

EXHIBIT XXIII

INSTRUCTIONS FOR USE OF GUIDELINES
FOR EVALUATION OF SCHOOL HEALTH SERVICES

The evaluation of school health services may be done by the school nurse for her own school district. However, use of a school nurse, school nurse supervisor, on school health nursing consultant from outside the school district will usually result in a more objective evaluation of the program. A peer review can usually be arranged with a school nurse from a nearby school district.

The evaluation criteria are divided into four major divisions, each with several sections. They are:

Guidelines for Evaluation of School Health Services

I. General School Health Services.

Policies, procedures, responsibilities, resources, health council, consultation, health records, evaluation.

II. Specific School Health Service Personnel.

Job description, objectives, supervision, inservice, health assessments and examinations, screening programs, referrals, conferences, counseling, communicable disease control, health room.

III. Vision Screening Programs.

Test procedure and practices, frequency, and follow-through.

IV. Hearing Screening Program.

Test procedures and practices, frequency, and follow-through.

The "quality of provision or practice" is divided into five categories:

0 - Provision not made, or practice not followed,
1 - Poor, 2 - Fair, 3 - Good, 4 - Excellent.

The appropriate category should be circled after each item in the evaluation. If additional individual notations are needed to clarify meaning, this can be written below that item. Recommended steps to be taken for improvement should then be written at the end of each section.

A total score for evaluation of the School Health Services can be arrived at by adding all the numbers circled for "quality of provision or practice." There are 448 possible points with the following breakdown.

0 - 55	Not acceptable program
56 - 168	Poor program
169 - 280	Fair program
281 - 392	Good program
393 - 448	Excellent program

GUIDELINES FOR EVALUATION OF SCHOOL HEALTH SERVICES

Criteria	Quality of Provision or Practice				
I. GENERAL SCHOOL HEALTH SERVICES	N	P	F	G	E
A. Purposes and scope of the school health program have been defined by written policies	0	1	2	3	4
B. Specific, written school health procedures are available for:					
1. Emergency care of ill or injured students	0	1	2	3	4
2. Medications given in the schools	0	1	2	3	4
3. Control of communicable disease	0	1	2	3	4
4. Reporting child abuse	0	1	2	3	4
5. Compliance with immunization law	0	1	2	3	4
6. Health component of Handicapped Children's Educational Act	0	1	2	3	4
C. Responsibilities of different classifications of school health personnel are clearly defined and applied	0	1	2	3	4
D. Community health resources are used in the school health program	0	1	2	3	4
E. A school health council or committee of school and community people has been organized and is functioning effectively	0	1	2	3	4
F. Consultive Services:					
1. Physicians are available for consultation and advice	0	1	2	3	4
2. Dentists are available for consultation and advice	0	1	2	3	4
3. The public health nurse serving the school district area is a consultant to the school health team	0	1	2	3	4

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
G. Cumulative health records are maintained K-12 on all students and include	0	1	2	3	4
1. Major health problems are tagged	0	1	2	3	4
2. Screening programs are recorded annually for both pass and fail	0	1	2	3	4
3. All health information obtained on the student is recorded on and/or filed in this health record.	0	1	2	3	4
4. Health records are readily accessible to appropriate school personnel	0	1	2	3	4
H. The school health services program undergoes periodic evaluation and revision	0	1	2	3	4

Recommended steps to be taken:

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Criteria	Quality of Provision or Practice				
II. SPECIFIC SCHOOL HEALTH SERVICES PERSONNEL	N	P	F	G	E
A. There is a written job description for the school nurse	0	1	2	3	4
B. There is a written job description for health aids and other health service personnel, such as technicians and school physicians	0	1	2	3	4
C. There are written objectives for the school nursing program	0	1	2	3	4
D. There is a qualified school nurse supervisor or coordinator or consultant available to give direction and advice*	0	1	2	3	4
E. The number of health personnel is adequate to fulfill the objectives of the school health service program	0	1	2	3	4
F. Inservice training is available and a reasonable amount of released time is available to health personnel for attending staff meetings, workshops, and continuing education programs	0	1	2	3	4

Recommended steps to be taken:

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*Refer to Chapter II for information on school nurse supervision and/or consultation.

Criteria	Quality of Provision or Practice				
G. Health Assessments by the school nurse are:	N	P	F	G	E
1. Completed on all kindergarten students	0	1	2	3	4
2. Completed on all new students to the school district	0	1	2	3	4
3. Completed by request on those students staffed into special educational programs	0	1	2	3	4
4. Completed on all students referred by school personnel or parents for a suspected health problem	0	1	2	3	4
5. Completed as needed on those students with a known health problem	0	1	2	3	4
H. Health examination by the doctor or nurse practitioner are:					
1. Requested on all new students entering the school district	0	1	2	3	4
2. Requested periodically about three times during the student's school life	0	1	2	3	4
3. Required on all secondary students competing in inter-school athletic competition	0	1	2	3	4

Recommended steps to be taken:

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
I. Screening programs are conducted annually by the school nurse or other trained personnel	0	1	2	3	4
1. Written procedures are available and being followed for:					
. vision	0	1	2	3	4
. hearing	0	1	2	3	4
. height and weight	0	1	2	3	4
. tuberculosis skin testing	0	1	2	3	4
. dental	0	1	2	3	4
. scoliosis	0	1	2	3	4
. other (list) ____________________	0	1	2	3	4
________________________________	0	1	2	3	4
________________________________	0	1	2	3	4
2. The school nurse initiates follow-up steps to ensure further evaluation or care for all students failing screening procedures	0	1	2	3	4
3. The teachers receive written notification of the names of any students who fail screening	0	1	2	3	4
4. Students referred for further evaluation or care are followed to see that such was obtained	0	1	2	3	4
5. The school nurse shares the evaluation recommendations with teachers and records it on student's health record	0	1	2	3	4

Recommended steps to be taken:

Criteria	Quality of Provision or Practice				
J. School personnel -- nurse referrals and conferences:	N	P	F	G	E
1. School personnel are advised and encouraged to observe students for possible health deviations	0	1	2	3	4
2. There is an established, known system by which the school personnel can make referrals to the school nurse	0	1	2	3	4
3. The school nurse provides feedback to school personnel on referrals they have made	0	1	2	3	4
4. Teacher-nurse conferences are held to inform teachers of students with health problems, or a list is furnished to the teachers of those students with health problems	0	1	2	3	4
5. Inservice is held at least annually with the teachers on how to handle health problems and emergencies in the school setting, e.g. epileptic seizures, diabetic coma, insulin reaction, reporting serious accidents or illness	0	1	2	3	4

Recommended steps to be taken:

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Criteria	Quality of Provision or Practice				
	N	P	F	G	E
K. Health counseling is available to pupils, parents, and school personnel	0	1	2	3	4
1. Parents are encouraged to confer with the school nurse when an adaptable school program is needed for a student due to a health problem	0	1	2	3	4
2. Time is available for students to talk with the school nurse about their concerns, or for the school nurse to discuss her screening findings with the student.	0	1	2	3	4
3. The school nurse can make home visits in cases of pupils having special health problems	0	1	2	3	4
4. Parents are informed of the results of health assessments and failures in screening programs either by telephone or written notice	0	1	2	3	4

Recommended steps to be taken:

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
L. Handicapped or chronically ill students are identified in the school district	0	1	2	3	4
1. Each of these students are seen at least twice a year by the school nurse in an individual conference to discuss their concerns	0	1	2	3	4
2. Special instructions and services are provided for these handicapped or chronically ill students when it is necessary	0	1	2	3	4
3. School personnel are informed of the special needs of the handicapped or chronically ill student	0	1	2	3	4
4. Special facilities are available to the students with handicapping conditions	0	1	2	3	4

Recommended steps to be taken:

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
M. Communicable disease control (including nuisance diseases) is part of the school health services program	0	1	2	3	4
1. School personnel are prepared to recognize signs of suspected communicable or nuisance diseases occurring in school students	0	1	2	3	4
2. School nurses report immediately to the principal and local health agency any of the following conditions - diphtheria, animal bites, measles, acute encephalitis, polio, smallpox, public gathering outbreaks (e.g. food poisoning)	0	1	2	3	4
3. School nurses report on a weekly basis to the principal and the local health agency any other communicable or nuisance disease*	0	1	2	3	4
4. Provisions are made for isolating sick students until they are removed from school	0	1	2	3	4
5. Students with a communicable or nuisance disease do not return to school until the condition has been remediated	0	1	2	3	4
6. The school health service correlates its plans for disease prevention and control with the community program	0	1	2	3	4
. [illegible]ce officer or office secretaries report to the school nurse the name of any student reported to have a communicable disease	0	1	2	3	4
8. The school nurse or specifically trained health service personnel does throat cultures on all students with symptoms of strep throat, or refers them to their family doctor for a throat culture in keeping with local school policies.	0	1	2	3	4

Recommended steps to be taken:

*See Chapter IV for types of diseases to be reported.

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Criteria	Quality of Provision or Practice				
	N	P	F	G	E
N. A school health office or adequate work space is available in every school	0	1	2	3	4
1. The nurse has available to her a desk with drawers, files, or cupboards for health records and supplies, and an appropriate number of chairs	0	1	2	3	4
2. A telephone is available for private conversations concerning the school health service program	0	1	2	3	4
3. First aid supplies are available throughout the school year	0	1	2	3	4
4. Privacy is possible in the school health office for conducting health counseling and health assessments	0	1	2	3	4
5. There is one cot available for every 400 students in the school	0	1	2	3	4
6. The cot has a washable cover, or disposable sheets and pillow covers are used	0	1	2	3	4
7. There is a locked cabinet or container for storage of prescription drugs brought to school by students	0	1	2	3	4
8. Hot and cold water and ice are easily accessible to the school health services personnel	0	1	2	3	4

Recommended steps to be taken:

III. VISION SCREENING PROGRAM

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
A. Vision screening includes testing for far point vision	0	1	2	3	4
1. Other vision screening *may* include:					
. near point	0	1	2	3	4
. muscle imbalance	0	1	2	3	4
. depth perception	0	1	2	3	4
. color blindness	0	1	2	3	4
B. Vision screening is completed at kindergarten and 1st, 3rd, 5th grade levels, once at junior high level once at sernior high level, for all children new to the school system, and for all children referred by school personnel	0	1	2	3	4
C. Vision screening is provided for all high-risk children including:					
1. Those who are enrolled in special education programs	0	1	2	3	4
2. Those who are being evaluated for staffings	0	1	2	3	4
3. Those who repeat a grade	0	1	2	3	4
4. Those who failed vision screening during the previous year and did not get glasses	0	1	2	3	4
D. Vision screening criteria which indicate that student requires additional evaluation are as follows:					
1. Visual acuity test according to Snellen E Test -					
. Refer a child 4 or 5 years old who fails the 40 line in either eye	0	1	2	3	4
. Refer a child 6 or older who fails the 30 line in either eye	0	1	2	3	4
. Refer any child who has a two-line differential between eyes	0	1	2	3	4
2. Refer if there is possible loss in any of the areas of optional type of vision screening.	0	1	2	3	4

Criteria	Quality of Provision or Practice N	P	F	G	E
E. All students who failed vision screening received further evaluation	0	1	2	3	4
F. All students with severe or handicapping eye problems are under professional care	0	1	2	3	4

Recommended steps to be taken:

Crite[illegible]	Quality of Provision or Practice				
IV. HEARING SCREENING PROGRAM	N	P	F	G	E
A. Manually administered, individual, pure tone air conduction screening procedure is provided annually for identification audiometry (initial screening)	0	1	2	3	4
B. Identification audiometry is provided for all students in grades kindergarten, one, two and three, plus once at the junior high level and once at the senior high level, for all children new to the school system, and for all children referred by classroom teachers or other school personnel	0	1	2	3	4
C. Identification audiometry is provided for all high risk children including:					
1. Those who are enrolled in special education programs	0	1	2	3	4
2. Those who repeat a grade	0	1	2	3	4
3. Those who failed a threshold test during the previous school year	0	1	2	3	4
4. Those who have a medical problem with hearing impairment	0	1	2	3	4
D. Regular classroom teachers are provided with information on symptoms to watch for in referring children for hearing screening, along with referral forms or written procedures to make such referrals	0	1	2	3	4
E. Identification audiometry includes pure tone air conduction at the following test frequencies and levels (re: ANSI, 1969): 500 Hz - 25 dB 1000 Hz - 20 dB 2000 Hz - 20 dB 4000 Hz - 25 dB 8000 Hz - 25 dB (optional)	0	1	2	3	4

Criteria	Quality of Provision or Practice				
	N	P	F	G	E
F. Identification audiometry programs are supervised by an audiologist or someone specifically trained in audiometry	0	1	2	3	4
G. Failure to respond to the specified screening levels at any one frequency in either ear constitutes failure	0	1	2	3	4
H. All failures are rescreened within the same session in which they failed or within one week	0	1	2	3	4
I. Failures on rescreening are referred immediately for threshold screening or audiologic evaluation by an audiologist or person specifically trained in threshold audiometry	0	1	2	3	4
J. Audiometers used for screening are calibrated to American National Standards Institute specifications initially (ANSI S3.6 1969), are checked for calibration at least annually, and are recalibrated when necessary	0	1	2	3	4
K. All students who fail identification audiometry receive threshold screening in the school or by referral	0	1	2	3	4
L. All students with known hearing problems are under medical care	0	1	2	3	4
M. All students with educationally significant hearing loss are identified during the threshold screening and are referred for further educational evaluation	0	1	2	3	4

Recommended steps to be taken:

CHAPTER X

REFERENCES AND RESOURCES

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Agencies

1. Colorado Department of Education
State Office Building
201 E. Colfax Avenue
Denver, Colo. 80203

A health education consultant is available to all school nurses and school districts for consultation in health education and curriculum development.

2. Colorado Department of Health
4210 E. 11th Avenue
Denver, Colo. 80220

Consultants are available in communicable disease control, health education, chronic disease, occupational and radiological health, speech and hearing, dental health, nutrition, alcohol and drug abuse, emergency medical services, as well as nursing. There are nursing consultants for adult health, child health, family planning, handicapped children, maternity, mental health, school health, and generalized public health.

3. Colorado High School Activities Association
11351 Montview Boulevard
Aurora, Colo. 80010

Publishes the guidelines for the medical aspects for both junior high and senior high sports in Colorado.

EXHIBIT XXIV

Calendar of Annual Events

This calendar was taken from Chase's Calendar of Annual Events - 20th year - 1977, by William D. Chase, Apple Tree Press, Box 1012, Flint, Michigan, 48501. The list presented here does not contain all the events in Chase's Calendar, but only those that might relate to school health interests.

January

Birth Defects Month

National Education Week on Smoking (2nd week)

National Stop Smoking Week (2nd week)

School Nurse Day (4th Wednesday)

February

American Heart Month

National Children's Dental Health Week (1st week)

March

Red Cross Month

Save Your Vision Week (1st week)

National Poison Prevention Week (3rd week)

Teachers' Day (4th Monday)

April

Cancer Control Month

Defensive Driving Week (1st week)

National Rural Health Week (1st week)

World Health Day (1st Thursday)

Bike Safety Week (3rd week)

Earth Week (Environment) (4th week)

National Volunteer Week (4th week)

Secretaries' Day (4th Wednesday)

May

Mental Health Month

Be Kind to Animals Week (1st week)

National Family Week (1st week)

National Hospital Week (2nd week)

June

National Safe Boating Week
(1st week)

September

American Indian Day
(4th Friday)

Mexican Independence Day (16th)

October

Child Health Day
(1st Monday)

Fire Prevention Week
(2nd week)

National School Lunch Week
(2nd week)

National Pet Health Week
(2nd week)

National Clean Air Week
(4th week)

November

National Diabetes Month

American Education Week
(2nd week)

Youth Appreciation Week
(2nd week)

December

Human Rights Day (10th)

Human Rights Week (10th - 17th)

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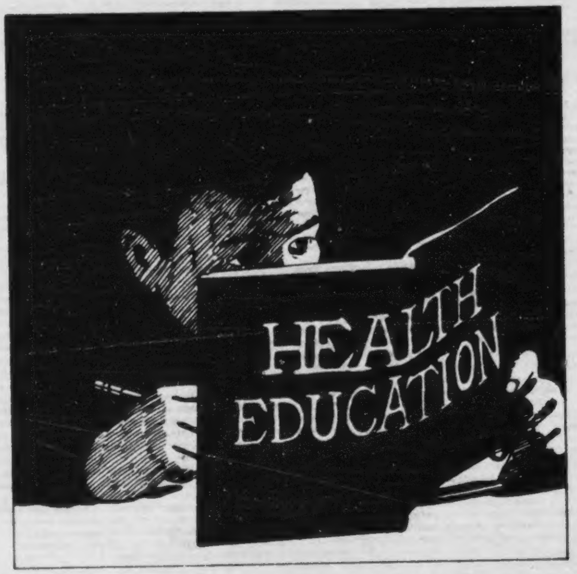

HEALTH
EDUCATION

HEALTH EDUCATION

SECTION II

SCHOOL HEALTH EDUCATION

Health education is the second component of a comprehensive school health program. Focusing on the health knowledge, attitudes and behaviors of students and staff, it complements both the services and the healthful school environment segments of the program.

This section of the manual is intended: (1) to explore the rationale for developing a health education program, (2) to suggest steps in program development, and (3) to provide tools to facilitate the development of such a program in the local district.

A special note of thanks goes to Evelyn Smith, Colorado Springs Health Education Coordinator, who helped to shepherd this section from initial outline through final review and rewrite.

CHAPTER XI

STATEMENT OF PHILOSOPHY

Good health has long been recognized as a significant factor in the development of the total person. In the school situation, good mental and physical health increases the students' ability to participate in classroom activities and to take advantage of the educational opportunities offered. As adults, good health frees us to be productive, contributing members of society.

Health education is a means to the goal of good health throughout life. An effective program in health education can increase the student's level of health knowledge, provide him with opportunities for critical thinking and problem solving, and improve the level of health skills which a student can utilize in his/her everyday life. It has the potential for increasing the physical and mental health of the individual, and enhancing the quality of life by significantly reducing those health problems susceptible to educational intervention.(1)

Statement of Need

The rising cost of medical care combined with changing disease patterns are responsible for renewed interest in health education. In 1976, the national health care bill totaled $138 billion. This includes money spent by the government, insurance systems, and the consumer on prescriptions, doctors' fees and hospital bills. The amount is expected to double in the next five years. In Colorado, an estimated $1.7 billion is spent each year on health services, with less than 1/2 of 1 percent of this spent on prevention. Economic considerations force us to look for more effective ways to prevent disease conditions before they require costly treatment, and to educate the public to better use of health care resources and personnel.

Likewise it is becoming obvious that the major disease conditions in the U.S. do not respond well to crisis care. Heart, cancer, and stroke have replaced communicable diseases as major threats to life in our society. In Colorado in 1976, the major causes of death were heart, cancer and stroke, followed by accidents, influenza-pneumonia, respiratory disease, suicide, cirrhosis of the liver, arteriosclerosis, and diabetes. Accidents are the number one killer among the school-age population; suicide is the second most common cause of death among Colorado teenagers. (See Exhibit XXV for further information.)

National surveys provide other indices of major health problems existing in the population. They provide the following estimates:

- ten million Americans are malnourished; 20 percent of the population is obese
- the average youth age 16 has seven decayed, missing or filled teeth; 60 percent of young adults have gum disease; 20 million Americans have lost all their teeth
- an estimated ten percent of the population is in need of some form of psychiatric care; 60 percent of the hospital beds are filled with patients whose problems are psychologically related
- venereal disease has reached epidemic proportions in recent years and, next to the common cold, is the most prevalent communicable disease in the U.S.; it has increased 324 percent between 1965 and 1975
- half of all blindness is preventable
- 19.8 percent of high school students rated themselves as misusers of alcohol; nine million Americans have alcohol-related problems

Each of these conditions is intimately related to patterns of living learned throughout life. Their control is not accomplished by crisis care or outside intervention, but through individual responsibility and action and programs of prevention begun early in life.

Role of the Schools

Several major professional associations including the National Education Association, the American Public Health Association and the National Parent Teachers Association have produced position papers which explore the role of the school in health education. Following are excerpts from some of the postion papers:

- The National Parent Teachers Association, the largest voluntary organization in America, was stimulated by critical health issues and its concern for the health of children to adopt a Position Statement on Health Education. The PTA "supports comprehensive school health education programs . . . and urges governmental agencies at all levels to provide necessary funds . . ., and to establish higher priorities for these programs on a level comparable to other curricular subjects."(2)

- The American Medical Association has stated that "health education must begin at a young age and continue throughout life. Only in this way can the state of the nation's health be raised to the level which scientific progress makes available."(3)

- The Education Policies Commission of the National Education Association as early as 1961 stated "The central purpose of education is to develop rational powers of the individual or his capacities to think and reason . . . . Basic to this development is physical health since disease, defects, or disability may interfere with learning. Mental health is also of profound importance; with it the pupil may have the desire and respect for learning that promotes optimum mental performance; without it the likelihood of such development is drastically reduced if not rendered impossible . . . .(4)

- The American Public Health Association believes that "health education should be a continuing process, from conception to death, and that such education be coordinated, and integrated in all community planning for health." (See Exhibit XXVI.)

- President Carter in an address on health issues stated "We must stress health and nutrition education. Our public schools could do more to teach our young people the dangers of drinking, smoking, using drugs, and over-eating and eating the wrong kinds of food."(5)

- A Health Education Task Force comprised of school administrators, school health coordinators, and representatives from health agencies was convened by the Colorado Department of Education in 1975. They made the following recommendations:

  1. That all school districts in Colorado be encouraged to provide a well-rounded comprehensive health education program for all children in the district.

  2. That efforts be directed at preparing teachers, administrators, and staff to deal with knowledges and attitudes related to health education.

  3. That all districts/Boards of Cooperative Services have available health coordinators or adequate staff to develop and coordinate programs.

  4. That resources and materials necessary to carry out effective programs be made available to all districts.

  5. That special effort be directed toward the development of school-community health education programs.

  6. That the Colorado Department of Education assume a leadership role in those areas related to school health education.(6)

Legislation

In recognition of the increasing need for prevention and health education in the schools, the Colorado legislature in 1975 passed the Colorado Health and Survival Education Act (C.R.S. 1973, as amended by S.B. 286, 1975 General Assembly). (See Exhibit XXVII.)

The legislation declares that "health survival education is an essential element of public education in the state of Colorado." It also states that "the school system is the most logical vehicle for conveying to children and parents significant health information and developing an awareness of the value of good health to the individual and the community." The purpose of the article is to "to foster the development and dissemination of educational activities which will assist Colorado students, school nurses, teachers, administrators, parents, and others in the understanding and appreciation of health needs and problems and their solutions."

Based on the legislation, the Department of Education is required to provide technical assistance upon request to districts or boards of cooperative services wishing to develop and submit a proposed program for health and survival education.

Specifically addressed in the legislation are:

1. the design, development and implementation of training programs for teachers, administrators, and other appropriate persons
2. the planning and activation of school programs to improve health and survival education
3. guidelines for teacher certification in the area of health
4. the responsibility of the Department of Education and the Department of Health in establishing guidelines and priorities for the distribution of state funds

The legislation is permissive in nature; it does not mandate health education programs in individual districts. It does establish a legislative position and does define the role of state agencies with this regard.

Legislation passed in 1887 requires that the effect of use of alcohol be taught. The following reference is made in Colorado School Laws 1976:

> 22-1-110. Effect of use of alcohol to be taught. The nature of alcoholic drinks and narcotics, and special instruction as to their effects upon the human system in connection with the several divisions of the subject of physiology and hygiene, shall be included in the branches of study taught in the public schools

> of the state. They shall be studied and taught, as thoroughly and in the same manner as other like required branches are taught in said schools, by the use of text books designated by the board of directors of the respective school districts.
>
> 22-1-111. Failure to teach temperance. It is the duty of the proper officers in control of any public school to enforce the provisions of this section and section 22-1-110. Any such officer, school director, committee, superintendent, or teacher who refuses, fails, or neglects to comply with the requirements of said sections or to make proper provisions for the instruction required, in the manner specified by section 22-1-110, for all pupils in each school under his jurisdiction, shall be removed from office, and the vacancy shall be filled as in other cases.

The manner in which the effects of alcohol are taught is determined by the school district. Technical assistance in program design is available from the Department of Education.

Health and Health Education Defined

A Definition of Health

The World Health Organization defines health as "the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Health is a changing ability to carry out daily tasks with vigor and alertness, with ample energy to enjoy leisure pursuits and to cope with unforeseen emergencies. Good health enhances all aspects of the human experience.

In his book on health education, Robert Russell personalizes the definition of health by exploring what health can mean to the individual.

> *"Health is . . . feelin' good when you get up in the morning . . . it's feelin' good even when you miss two spelling words . . . it's enjoying the freedom of recess but not really minding going back to try to learn something more . . . it's climbing a tree to look at a bird's nest . . . it's feeding your cat, even when nobody reminds you . . . it's being able to play hard, with both kids you like and don't . . . it's feelin' good about goin' to bed, 'cause there'll be more good and fun things to do tomorrow.*
>
> *"It's being satisfied with the body you have and yet wanting to maintain and even improve its condition and appearance . . . it's being satisfied with where your head's at and yet willing to experience and learn new things and even change your ideas . . .*

> *it's being satisfied with what sex you are and yet being real interested in what the opposite is like . . . it's knowing you are an individual but getting real satisfaction out of relating to others and not necessarily being No. 1.*
>
> *"It's getting satisfaction from your work without having your whole identity being what you do . . . it's getting married because you want to and are ready to and then keeping a balance between the real joys of marriage and the real pains of living closely with a person who isn't like you, in certain ways . . . it's taking care of a body that's been functioning quite a few years, balancing off what you can do with what you no longer can.*
>
> *"And when you get older, it's living with a certain amount of pain and discomfort without being a self-centered martyr and yet without letting it interfere too much with the enjoyable things you still can do . . . it's living with the fact that what you'll hear from many of your friends is about their infirmities . . . it's making new friends when it would be easier just to remain lonely . . . it's accepting the fact that you have to be dependent on others in ways but still doing as much as you can for yourself . . . it's realizing that your dependence is a means by which younger persons can get the satisfaction of being helpful to someone in need."*(7)

A Definition of Health Education

Health Education is a means to the goal of good health throughout life. It may be defined as "an applied discipline that seeks to improve the quality of life by helping people establish patterns of living based on knowledge, attitudes, values and practices that will enhance optimal health and delay the onset of disease. It is interdisciplinary in scope and draws on medicine, education research, the behavioral, biological and natural sciences for its content and methodology."(8)

As defined by the Colorado Legislature (see Exhibit XXVII), "health and survival education includes, but is not limited to such concerns as communicable disease, community health, consumer health, dental health, drug abuse (including alcohol and tobacco), environmental health, human growth and development, health careers, hereditary and developmental conditions, mental health, nutrition, personal health and physical fitness, and safety and emergency care."

The National Education Association and the American Medical Association worked cooperatively to produce a statement on what health education is and is not. The following statement focuses on formal health education activities.

HEALTH EDUCATION IS:

education for health; education for healthful living of the individual, family and community.

an academic field and subject. All of its content and objectives are intellectual and academic in nature. Its content must have meaning and purpose to the students now as well as in the future.

a relatively new discipline. The natural (biological), the behavioral, and the health sciences provide its foundation.

a combination of facts, principles, and concepts pertaining to healthful living. These constitute its body of knowledge.

a body of knowledge identified, organized, synthesized, and utilized in appropriate courses and experiences and sequentially arranged to form the discipline.

derived from sociology, psychology, educational psychology, and the behavioral sciences--its purpose is to change health behavior favorably.

a needed approach to bridge the gap between scientific health discoveries and man's application of these discoveries in daily life.

an integral part of the curriculum at every level. It is an essential element in the general education of all students.

the education component of a school, college, or university health program.

a contribution to the well-educated individual by providing meaningful health experiences which can change health behavior.

best achieved by developing the rational powers of man (critical thinking). This enables him to make wise decisions and solve personal, family, and community health problems.

based upon and improved by basic and applied research.

best conducted by professionally prepared health educators from accredited colleges and universities.

HEALTH EDUCATION IS NOT:

hygiene of yesteryear. It is not "blood and bone" hygiene, nor is it physiological hygiene.

anatomy or physiology or both of these combined. These fields serve as its foundation, but do not contribute the major concepts of its body of knowledge. They are necessary as background to understand health concepts applied to living.

a pure science, but an applied science. It is an applied science concerned with man's understanding of himself in relation to health matters in a changing society.

physical education. Health education and physical education are separate and distinct fields. They have similiar goals and are closely related, but their activities are completely different.

physical fitness. It contributes to the total fitness of man. It is not synonymous with muscle fitness.

driver education. Health education is related to driver education through its safety area.

a requirement course organized to deal with legal provisions of alcohol, narcotics, and fire prevention. These are essential problems that should be incorporated with other basic problems to provide a structure course or program.

rainy-day or incidental instruction. Health education must be carefully planned and incorporated in the curriculum. It must be taught in a wholesome learning environment in which pupil activities can be carried out, particularly through problem-solving situations, under the guidance of professionally prepared health educators.

only instruction on grooming practices, such as tooth brushing and combing the hair.

A Definition of a Health Education Program

A health education program is a planned and organized series of health educational activities or procedures implemented with appropriately prepared personnel, an integrated set of objectives sufficiently detailed to allow evaluation, and appropriate administrative support and funding.

CHARACTERISTICS OF A GOOD HEALTH EDUCATION PROGRAM

The following characteristics have been defined by the Colorado School Health Council as basic to an effective, comprehensive health education program.

1. Leadership - Each school should have a person that can be indentified as having the responsibility for coordinating and evaluating the total comprehensive health education program.

2. Broad Scope - A comprehensive health education program should include, but not be limited to, the following:

   - Communicable/Chronic Disease
   - Mental Health/Personality Development
   - Growth and Development
   - Family Life Education/Parenting
   - Environmental Health
   - Survival Skills/Emergency Care
   - Alcohol/Drug Abuse
   - Consumer/Community Health
   - Nutrition
   - Personal Health/Physical Fitness

3. Sequential - The above topics should be presented in a coordinated, sequential, unified manner. The subjects should be introduced at the child's entrance into school and be developed/reinforced throughout the total school experience.

4. Identifiable - The health objectives for each grade level should be identified in writing. The implementation of these objectives should be observable in the classroom and school environment.

5. Supported - Community support, administrative support, teacher and school health personnel support are all vital to the effective operation of the health education program.

6. Balanced - There is a need to provide varied program approaches which emphasize attitudinal, decision-making and valuing processes, as well as factual information.

7. Adaptable - Health information is undergoing constant change through research and experience. A dynamic program must be receptive to continuous evaluation and alteration.

8. Prepared Teacher - Even with the above program characteristics, the instruction can be only as good as the person who is teaching. Therefore, teacher preparation/training becomes the key factor to the success or failure of the health education program. If such teaching is to be effective, teachers must have an adequate knowledge and skill base and operate with an attitude of sincere interest, honesty and respect for the individual.

These characteristics form the basis for a health education program and will be referenced in the remainder of the health education section.

---

(1) "Comprehensive Health Education Act," House Bill 2600, 94th Congress, First Session, February 3, 1975.

(2) "Position Statement on Federal and State Support to Comprehensive School Health Education Programs," National Parent Teachers Association, 1970.

(3) "Fact Sheet - School Health Education in North Carolina," North Carolina Department of Public Instruction, 1977.

(4) *Central Purpose of Education* produced by the Education Policies Commission of the National Education Association, 1961.

(5) Speech given by presidential candidate Carter to the American Public Health Association Meeting, Miami, Florida, October 19, 1976.

(6) *Colorado School Health and Survival Education Program: Report to the Legislature*, Colorado Department of Education, Denver, Colorado, 1976.

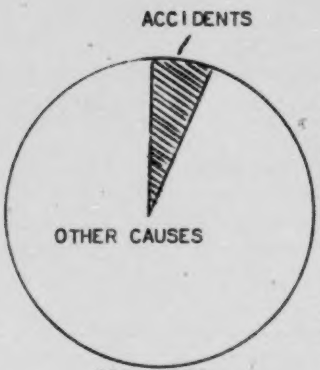
(7) Russell, Robert, *Health Education*. Joint Committee on Health Problems in Education, National Education Association and the American Medical Association, 1975.

(8) Dr. Bryan Cooke, Chairman, Department of Health and Safety Education, University of Northern Colorado, Greeley, Colorado.

EXHIBIT XXV

SOME SELECTED HEALTH PROBLEMS OF OUR YOUTH
COLORADO 1976

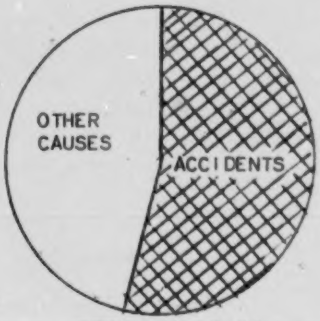
Deaths From Accidents



ALL AGES

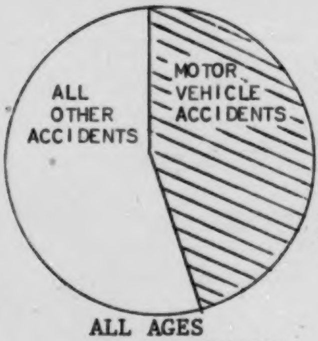
For all ages, accidents rank as the 4th leading cause of death and account for 7.5% of all deaths.

Among persons 10-24 years of age, the No. 1 killer is accidents and 56.7% of all deaths in this age group are the result of various types of accidental injury.



PERSONS 10-24

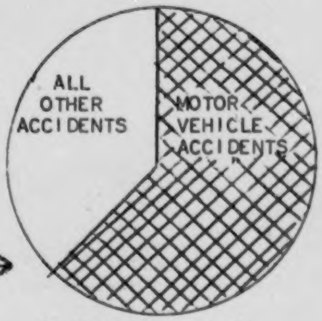
Motor Vehicle Deaths



ALL AGES

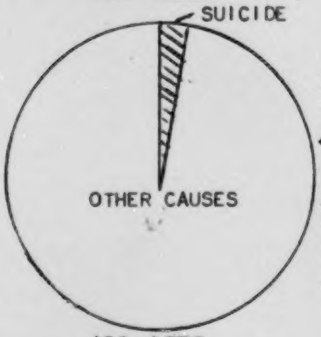
Of the 1,346 accidents to Coloradoans of all ages, 630 or 46.8% were attributed to motor vehicle accidents.

Of the 394 accidents to persons 10-24 years of age, 246 or 62.4% were attributed to motor vehicle accidents.



PERSONS 10-24

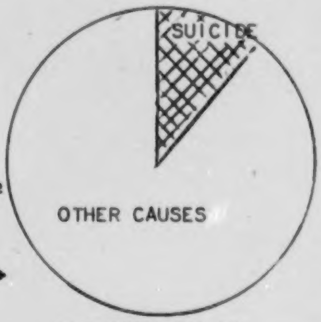
Deaths From Suicide



ALL AGES

For all ages, suicide ranks as the 6th leading cause of death and accounts for 2.6% of all deaths.

Among persons 10-24 years of age, suicide is the No. 2 killer and accounts for 13.5% of all deaths occuring in this age group.

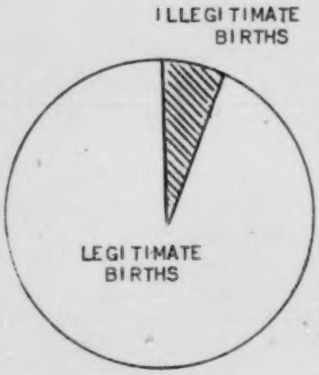


PERSONS 10-24

Prepared by:
Statistics Unit
Records & Statistics Section
Colorado Department of Health
8-2-77

SOME SELECTED HEALTH PROBLEMS OF OUR YOUTH
COLORADO - 1976

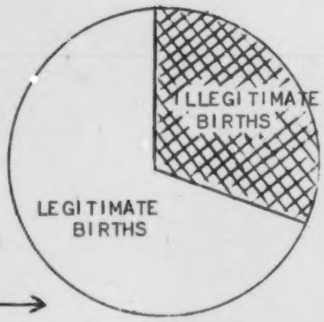
Illegitimate Births



ALL MOTHERS

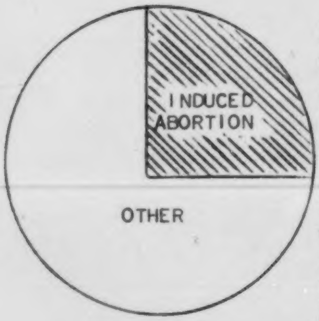
Colorado women delivered 40,978 babies during 1976. Of these, 4,465 or 10.9% were illegitimate. ←

Women under the age of 20 delivered 6,494 of these babies. In this teenage group of mothers 2,197 or 33.8% of the deliveries were illegitimate. →



MOTHERS UNDER 20

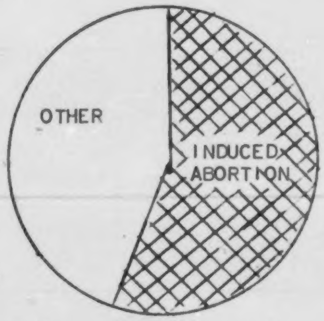
Induced Abortion - 1975



ALL WOMEN

For Colorado women, 10,466 pregnancies were terminated by induced abortion--an average of 25 induced abortion for every 100 live births and fetal deaths of 20 weeks gestation or more. ←

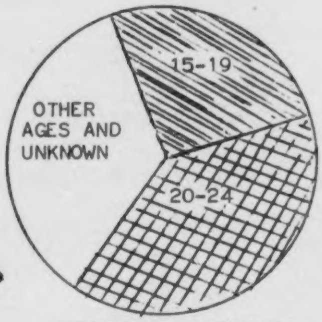
For women under age 20, 3,569 pregnancies were terminated by induced abortion--an average of 55 induced abortions for every 100 live births and fetal deaths of 20 weeks gestation or more. →



WOMEN UNDER 20

Venereal Disease

10,438 cases of venereal disease were reported in Colorado during 1976. 3,946 or 37.8% of these cases were found in persons 20-24 years of age. An additional 2,076 or 19.9% of the cases were found in younger persons--age 15-19 years. →



VENEREAL DISEASE BY AGE

Prepared by:
Statistics Unit
Records & Statistics Section
Colorado Department of Health
8-2-77

EXHIBIT XXVI

EDUCATION FOR HEALTH IN THE SCHOOL COMMUNITY SETTING

A Position Paper
by
American Public Health Association

The school is a community in which most individuals spend at least 12 years of their lives, and more if they have the advantages of early childhood programs, college education, and continuing education for adults. The health of our school-age youth will determine to a great extent the quality of life each will have during the growing and developing years and on throughout the life cycle. Their capacity to function as health educated adults will in turn help each to realize the fullest potential for self, family, and the various communities of which each individual will be a part.

The American Public Health Association believes that health education should be a continuing process, from conception to death, and that such education must be comprehensive, coordinated, and integrated in all community planning for health.

The school, as a social structure, provides an educational setting in which the total health of the child during the impressionable years is of priority concern. No other community setting even approximates the magnitude of the grades K-12 school educational enterprise, with an enrollment of 1973-74 of 45.5 million in nearly 17,000 school districts comprising more than 115,000 schools with some 2.1 million teachers. This is to say nothing of the administrative, supervisory, and service manpower required to maintain these institutions. Additionally, more than 40 percent of children aged three to five are enrolled in early childhood education programs. Thus it seems that the school should be regarded as a social unit providing a focal point to which health planning for all other community settings should relate.

Schools provide an environment conducive to developing skills and competencies which will help the individual confront and examine a complexity of social and cultural forces, persuasive influences, and ever-expanding options, as these affect health behavior. Today's health problems do not lend themselves to yesterday's solutions. Specificity of cause is multiple rather than singular. The individual must assume increasing responsibility for solutions to major public health problems, and consequently must be educated to do so.

Education for and about health is not synonymous with information. Education is concerned with behavior--a composite of what an individual knows, senses, and values and of what one does and practices. Factual data are but temporary assumptions to be used and cast aside as new information emerges. Health facts unrenewed can become a liability rather than an asset. The health educated citizen is one who possesses resources and abilities that will last throughout a lifetime-- such as critical thinking, problem-solving, valuing, self-discipline, and self-direction--and that lead to a sense of responsibility for community and world concerns.

The school curriculum offers an opportunity to view health issues in an integrated contest. It is designed to help the learner gain insights about the personal, social, environmental, political, and cultural implications of each issue. Planning for health care delivery, for example, is not simply a matter of providing for manpower, services, and facilities. These things must be considered in concert with housing, employment, transportation, cultural beliefs and values, and the rights and dignity of the persons involved. Nor will nutritional practices be improved substantially by programs based on groupings, labeling, or issuing stamps, because food practices and eating patterns are equally influenced by how, when, why, and with whom one eats.

APHA is concerned about the traditional crisis approach to health care. The expense involved in treatment, rehabilitation, recuperation, and restoration to health has sent medical costs soaring. More facilities, more services, and more manpower to staff the facilities and to provide the services appear to be the nation's leading health priorities. The alternative is a redirection of the nation's health goals towards a primary preventive--and constructive--approach to health, through education for every individual.

Because of vested interests, political pressures, mass media sensationalism, and health agency structures with categorical interests, health education programs in schools are compelled to deal with a multitude of separate health issues, with only a few of these given priority at any given time. Too frequently, programs developed to deal with crucial issues are eliminated although the problems remain, because another crisis emerges calling for more new crash programs. A revolving critical issue syndrome has been the result, with the same problems considered crucial a decade or more ago emerging once again. Focusing on selected categorical issues has potential value if time, energy, personnel, and money are available to sustain the emphasis and expand such efforts into an integrated and viable health education framework. A broad concept of healthful living that has consideration for psychosocial dimensions should be the basis for health education.

APHA is encouraged by recent developments in an increasing number of states which attest to recognition of the significance of a comprehensive health education program in grades kindergarten through twelve. Also encouraging are the exemplary programs being established in many school districts, and the expressed intention of the federal government to implement an action plan for "Better Health Through Education."

EXHIBIT XXVII

1975

An Act

SENATE BILL NO. 286. BY SENATORS H. Fowler, Stockton, Anderson, Brown, Cisneros, Groff, and Holme; also REPRESENTATIVES Webb, Barragan, Brown, Castro, Frank, Knox, Lucero, McCroskey, Taylor, and Valdez.

CONCERNING HEALTH EDUCATION IN SCHOOLS, AND MAKING AN APPROPRIATION THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Title 22, Colorado Revised Statutes 1973, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 25

Colorado Health and Survival Education

22-25-101. Short title. This article shall be known and may be cited as the "Colorado Health and Survival Education Act".

22-25-102. Legislative declaration. The general assembly hereby finds and declares that health survival education is an essential element of public education in the state of Colorado. The school system is the most logical vehicle for conveying to children and parents significant health information and developing an awareness of the value of good health to the individual and to the community. It is further declared that many of the serious health problems in Colorado are directly attributable to the insufficient health knowledge and motivation of the school-age population and the general public. Therefore, it is necessary that more effort and money be made available for health and survival education as a positive approach for improved health in Colorado. The purpose of this article is to foster the development and dissemination of educational activities and

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

materials which will assist Colorado students, school nurses, teachers, administrators, parents, and others in the understanding and appreciation of health needs and problems and their solutions.

22-25-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Health and survival education" includes but is not limited to such concerns as communicable diseases, community health, consumer health, dental health, drug abuse (including alcohol and tobacco), environmental health, human growth and development, health careers, hereditary and developmental conditions, mental health, nutrition, personal health and physical fitness, and safety and emergency care.

22-25-104. Administration. (1) There is hereby created a comprehensive health and survival education program for children and youths in kindergarten and grades one through twelve. Responsibility for the administration of this article shall rest with the department of education in cooperation with the department of health, pursuant to the Colorado rules and regulations to be adopted by the state board of education.

(2) The health and survival education program shall include the following:

(a) Design, development, and implementation of programs for the selection and training of health education instructors for teachers, administrators, and other appropriate persons.

(b) Planning and activation of initial or extended programs in schools of the state to improve health and survival education.

(c) Establishment of guidelines for teacher certification programs to assure more adequate teacher preparation.

22-25-105. Areas served. Pursuant to policies and regulations to be adopted by the board of education, each district school board or board of cooperative services may submit to the commissioner of education a proposed program designed to effectuate a health and survival education project in the district or school consistent with the purposes of this article. The department of education shall develop guidelines to be used by local schools and districts for development and submission of proposals.

22-25-106. Technical assistance. Upon request of a district school board or board of cooperative services, the department of education shall provide such technical assistance as is necessary to develop and submit a proposed program for health and survival education.

22-25-107. Program review funding. The commissioner shall, with the executive director of the department of health, review all health and survival education proposals submitted. For those proposals approved, the board of education, after considering recommendations of the department of health, shall establish priorities for the allocation of available funds.

22-25-108. Program appraisal required. The state board of education shall, at least thirty days prior to the 1976 session of the general assembly, transmit to the governor, to members of the Colorado general assembly, and to the chairmen of the senate and house committees on health and education the following: A statement of the overall health and survival education program, criteria for approval of proposed programs or projects, and the recommended level of funding for the overall program during fiscal year 1976-77. Each year thereafter the commissioner of education shall transmit to the above-named parties an appraisal of the programs or projects funded under this article and of the overall health and survival education program as to the effectiveness, efficiency, and utilization of resources, including therewith a statement of the overall health and survival education program for the coming fiscal year, the recommended level of funding for that year, and any other recommendations deemed by the commissioner to be appropriate.

22-25-109. Nonpublic personnel permitted to participate. Teachers, school nurses, or school administrators employed by a nonpublic school may participate as students in in-service education institutes or curriculum development programs conducted pursuant to this article, if such participants assume the pro rata share of the cost.

22-25-110. Student exemption. Any child whose parent presents to the school principal a signed statement that the teaching of disease, its symptoms, development and treatment, and the use of instructional aids and materials on such subjects conflicts with his religious beliefs shall be exempt from such instruction, and no child so exempt shall be penalized by reason of such exemption.

22-25-111. Sex education not required. This article shall not be construed to require the teaching of sex education as a specific area of instruction or as a part of health and survival education required by the state board of education.

22-25-112. Use of funds. In implementing this article, every effort shall be made to combine funds appropriated for this purpose with funds available from all other sources, federal, state, local, or private, in order to achieve maximum benefits for improving health and survival education.

SECTION 2. Appropriation. There is hereby appropriated out of any moneys in the state treasury not otherwise appropriated, for the fiscal year commencing July 1, 1975, to the department of education, the sum of twenty-four thousand dollars ($24,000), or so much thereof as may be necessary, for the administration and implementation of this act.

SECTION 3. Effective date. This act shall take effect July 1, 1975.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Fred E. Anderson PRESIDENT OF THE SENATE	Ruben A. Valdez SPEAKER OF THE HOUSE OF REPRESENTATIVES
Comfort W. Shaw SECRETARY OF THE SENATE	Evelyn T. Davidson CHIEF CLERK OF THE HOUSE OF REPRESENTATIVES

APPROVED ______________________________

Richard D. Lamm
GOVERNOR OF THE STATE OF COLORADO

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EXHIBIT XXVIII

GOALS OF EDUCATION
for the
ST. VRAIN VALLEY SCHOOL DISTRICT, RE-1J

9. Each student to develop and maintain skills in physical and mental health.

Objectives that lead to the attainment of this goal should facilitate the following educational outcomes:

(1) Developing and maintaining one's physical health.

(2) Protecting one's health and that of the community.

(3) Developing an understanding of the human body.

(4) Developing an awareness of, acceptance of, and appropriate expression of emotions.

(5) Demonstrating an ability to distinguish reality from fantasy.

(6) Participating in recreational activities.

(7) Managing one's self in traumatic experiences.

(8) Developing techniques and skills for satisfying needs.

(9) Developing mental and physical competencies for use of leisure time.

(10) Developing an awareness of the concepts of time and space.

CHAPTER XII

HEALTH EDUCATION PROGRAM PLANNING
TOOLS AND TECHNIQUES

To be effective, a health education program must be based on a careful planning process, as are all other areas of the school program. This chapter contains an overview of the planning process, followed by a more in depth exploration of tools and techniques to be used in selected stages of developing a health education program.

An Overview of Program Planning

The following is summary of the major steps in the program planning process. The district may at any point enlist the support, guidance, and technical assistance of personnel from the Department of Education in the planning and development of the school health education program.

1. An administrative decision must be made that health education is essential. The charge to develop or explore the development of a program should come from the board of education through the superintendent. Time, resources and personnel must be allotted to carry out the task.

2. An administrative appointment should be made of someone with responsibility for coordinating the program development process.

3. The coordinator, in conjunction with the district administration, establishes a health education advisory committee of interested parents, teachers, doctors, nurses, juvenile authorities, clergy, school administrators and others.

4. The School Health Advisory Committee should:

    a. Identify broad district goals in health. These will vary in each district. Review of established district priorities may reveal some health related goals already in existence.

    b. Identify the status quo of health education--what is being taught, who is in charge, what are the students learning?

c. Develop a statement of need. The needs in health education may be identified by measuring to what extent goals are being met by current practices.

d. Explore alternatives. Utilizing information gained from the needs assessment and reviewing the goals established, the health education committee should review alternative ways to meet the identified goals.

5. The School Board then, with the advice of the administration, should designate the program.

Detail of Program Planning

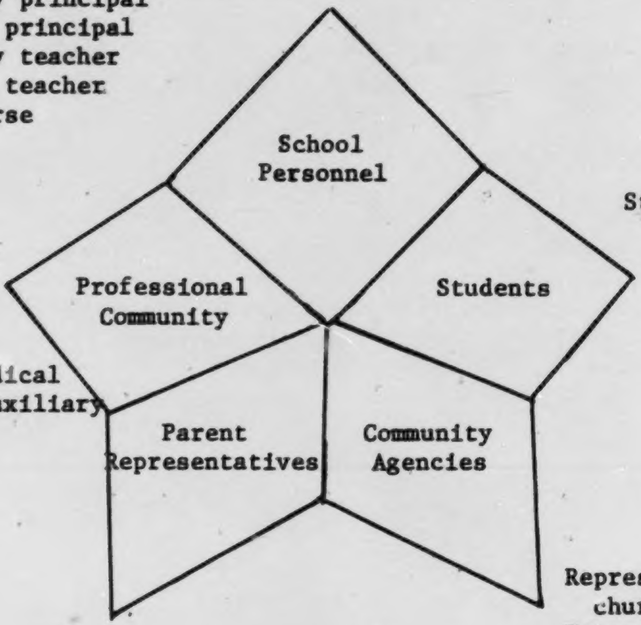
1. An adminstrative decision for including health education in the curriculum may be stimulated in several ways. The occurence of one or several health problems may draw attention to the need for school health programming. District priorities set through accountability may call for action in the area of health.

2. When appointing a staff member to coordinate the development of a school health program it is important to choose someone who has interest in doing so, has knowledge about health and curriculum building, and an ability to organize people's activities. This person may be the curriculum director, a health educator or an outstanding teacher who has interest and an adequate background. Time must be allotted to this employee to adequately carry out the task. This must not be another responsibility given an already busy staff member.

3. Following the appointment of a coordinator an important task at hand is to assemble a Health Council or Committee to help carry out the charge from the School Board. Health Committees typically include a number of parents, health professionals and voluntary health agency representatives from outside the school system as well as representatives of the school staff. It is recommended that this group function as a subcommittee of the accountability committee or as a special health task force of a larger district curriculum review committee. This will avoid duplication of effort and will provide for greater communication and better integration of findings and recommendations into the overall district program.

   On the following page is a model of a local school health council or subcommittee, with a suggested membership plan:

SCHOOL HEALTH COUNCIL MODEL



Superintendent or representative
Elementary principal
Secondary principal
Elementary teacher
Secondary teacher
School nurse

Student from
each school level

Local doctors
or dentists
Members of medical
or dental auxiliary

Representative of local
church group
Extension agent
Local mental health association
Representative of local
business organization
Representative of local
health department

Members of PTSA or
other representative
Parent advisory groups

To attach maximum importance to the task at hand it is suggested that the committee be called together by the superintendent or the school board.

Other points to keep in mind in developing an Advisory Council:

- Prospective members of the committee should be carefully selected on the basis of the task to be accomplished.

- An effective group size is seven to nine members. Additional school and community personnel may be recruited from time to time to provide input in their particular area of expertise. A larger group may be divided into smaller task forces to investigate portions of the study, convening as a whole to make decisions.

- A brief inservice session bringing all members into knowledge about the task is important so they may all begin with the same reference base.

- Meetings should be planned and agendas mailed to the committee well in advance so meetings may promote action rather than information gathering.

- Members should be regular in attendance. Persons who cannot attend regularly should be replaced by more active members.

- The group must have a specific task or charge, with responsibilities and expectations clearly outlined. A letter of understanding from the administration will help clarify the wishes of the administration, give direction to the committee, and assure an understanding of what will be done with the recommendations of the group. The following is a sample letter of understanding.

SAMPLE STATEMENT OF UNDERSTANDING

It is understood that:

(1) the Health Committee will consist of at least one parent, school nurse, one administrator, and a teacher representative from each level.

(2) the Health Committee will review the current status of health programs in the district. It may entail surveys of students, parents, and teachers. This will be done in conjunction with the district curriculum review committee.

(3) the Committee will prepare a report of findings and recommendations. This report will be reviewed by the administration and presented to the Board of Education at its March meeting.

(4) Implementation will begin in the Fall of '79 with time allotted for teacher inservice

(5) Sufficient funds will be allotted to carry out recommendations made by the Committee and accepted by the Board.

TEN SAMPLE PROGRAM OBJECTIVES IN HEALTH EDUCATION

(1) The student will demonstrate understanding of various communicable and non-communicable diseases, their possible causes, prevention, and treatment. He will exhibit skill in prevention and treatment of selected conditions.

(2) The student will understand the forces which affect his or her mental health. He will develop the ability to cope with stress and to enjoy the pleasures of life.

(3) The student will demonstrate an understanding of the different stages of physical and psychological development in themselves and their family members. He will exhibit skill in adjusting to these changes.

(4) The student will understand the roles and functions of families, and will be able to make wise decisions in this regard. He will demonstrate a knowledge of how to create a healthy environment for family members including children.

(5) The student will demonstrate an understanding of the relationship of environment and health. He will exhibit skills in making responsible decisions with regard to environmental health.

(6) The student will recognize potential hazards and understand how to prevent accidents. He will exhibit basic first aid skills.

(7) The student will demonstrate an understanding of the interrelationship of personal, chemical, and environmental forces in the use and abuse of alcohol and other drugs. He will exhibit skills in coping with these.

(8) The student will demonstrate an understanding of health care services and products. He will make wise choices concerning when, where, and how to seek care.

(9) The student will demonstrate an understanding of what constitutes proper diet. He will exhibit skills in selecting and preparing a proper diet for himself and family.

(10) The student will understand proper care of parts of the body including care of the teeth and the senses. He will understand the role of fitness to overall health and exhibit skills in selecting personal health and fitness practices.

4a. Identifying district goals in health education. The first questions that the school health committee must address is "where do we want to go in health education? What do we want the kids to know and do with regard to health? What are our goals?"

Committees seeking to establish district goals should seek input from the following sources within the district:

(1) Accountability committee reports: District priorities established through the school board are an indication of educational goals of the broader community. Frequently they will include health-related goals and outcomes such as "Developing and maintaining one's physical health . . . . Developing an awareness of, acceptance of, and appropriate expression of emotions . . . . Managing one's self in traumatic experiences." (See Exhibit XXVIII.)

(2) Parents: In the absence of clearly defined district priorities which would reflect parent and community interest, it may be necessary to survey parents regarding their health education goals for their children.

(3) Teachers, administrators: Since teachers and administrators will have primary responsibility to see that the goals and objectives are reached, it is essential that they be involved in the process of setting goals and objectives.

(4) Health professionals: Health professionals both in the school and in the community deal daily with health problems that could be avoided or reduced through proper health education.

(5) Students: An effective program in health education must consider student interests and readiness to learn.

In addition to local input, it is beneficial to review goals that have been established in the field. The following sample of district goals was compiled from models in the professional literature and samples from curriculum guides in existence around the state.

These goals and objectives are not to be considered state goals in health education, but merely as models to be reviewed and reacted to by local district health committees.

4b. Identify the status quo. A complete measure of the status quo of a district's health education program would include (1) an assessment of the level of student knowledge and performance, (2) a review of overall program characteristics and administrative practices, and (3) an interest and performance survey.

(1) Student knowledge and performance. Several nationally-recognized health knowledge tests exist. They can give some indication of the knowledge level of your students relative to other school groups across the United States. Below is a synopsis of several of the available testing programs. Prices listed are as of August, 1977 and are subject to change.

* * *

AAHPER (American Association for Health, Physical Education and Recreation) Cooperative Health Education Test, Form 4.

Available from: Educational Testing Service
1947 Center Avenue
Berkeley, California 94704

50 multiple choice questions covering consumer health, community health, international health, disease and disorders, personal care, growth and development, nutrition, mental health, drug use and abuse, safety and first aid.

For grades 4-6
Requires 40 minutes working time
Sample Kit: $3.50
Student Booklets: $7.00

* * *

AAHPER (American Association for Health, Physical Education and Recreation) Cooperative Health Education Test, Forms 3A and 3B.

Available from: Educational Testing Service
1947 Center Avenue
Berkeley, California 94704

50-item test covering consumer health, community health, international health, disease and disorders, personal care, growth and development, nutrition, mental health, drug use and abuse, safety and first aid.

For grades 7-9
Requires 40 minutes working time
Sample Kit: $3.50
Student Booklets: $7.00

* * *

Adult Proficiency Level (APL) Test--Health Content Area.

Available from: American College Testing - APL Program
P.O. Box 168
Iowa City, Iowa 52240

Forty-five multiple choice items. Tests skills necessary to function as healthy adult; reading level is approximately fifth grade.

Not a timed test
Expected publication date, November 1977.

* * *

Fast-Tyson Health Knowledge Test, revised 1975.

Available from: Dr. Charles Fast, Professor
Health Education
North East Missouri State College
Kirksville, Missouri 63501

One hundred multiple choice questions covering sex and family life, alcohol/drugs, safety and first aid, mental health, personal health, contemporary health, exercise/relaxation, nutrition, disease and consumer health.

For senior high
Requires 50 minutes working time
Sample packet: $2.00
Student booklets: $30.00 per package of 50
$55.00 per package of 100

* * *

Kilander-Leach Health Knowledge Test, revised 1972.

Available from: Dr. Glum Leach, Publisher
116 North Pleasant Avenue
Ridgewood, New Jersey 07450

One hundred multiple choice items covering sex and family life, alcohol/drugs, safety and first aid, mental health, personal health, contemporary health, exercise/relaxation, nutrition, disease and consumer health.

For senior high
Requires 50 minutes working time
Sample packet: $ .50 for individual copies
$6.00 for 35 copies

* * *

(2) Overall program characteristics. A review of overall program characteristics provides a second indicator of the status of the health education program. The following is a checksheet for program self-appraisal. It is based on the "Characteristics of a Good Health Education Program," outlined in Chapter XI.

HEALTH EDUCATION PROGRAM REVIEW

1. Leadership

	yes	no
a) Does your district have a person who is identified as having the responsibility for coordinating and evaluating the total comprehensive health education program?		
b) Do you have a person in each building that can be identified as having responsibility for health education activities?		
elementary		
secondary		

Comments:

2. Broad Scope

Which of the following topics are required for all students?

	elementary	secondary
Communicable/Chronic Disease		
Mental Health/Personality Development		
Growth and Development		
Family Life Education/Parenting		
Environmental Health		
Survival Skills/Emergency Care		
Alcohol/Drug Abuse		
Consumer/Community Health		
Nutrition		
Personal Health/Physical Fitness		

Comments:

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		yes	no
3.	**Sequential**		
	Do you have a written curriculum identifying which concepts will be taught at each level?	____	____

Comments:

If you have a guide, what percentage of your teachers are actively using the guide? ______

Do you have a mechanism by which teachers can share what health content is being presented at each level?	____	____

Comments:

4. **Identifiable**

How much health instruction does the average student receive between grades 7-12? ______

Comments:

How much time per day, on the average, is spent on health education in the elementary classroom: ______

Comments:

5. Supported

Do you have an active community-school health committee consisting of

___ parents ___ administrators ___ medical personnel

___ teachers ___ students?

Comments:

6. Balanced

Do you include the following approaches in your health program?

___ Factual information ___ Hands-on experiences and experiments

___ Decision-making processes ___ Values and attitudinal

Comments:

7. Prepared teachers

What preparation have the elementary teachers had in health education?

Are the teachers responsible for health education at the secondary level "endorsed" in health education?

7. Prepared teachers continued

What inservice sessions in health education have been attended by your staff in the past two years?

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

How does this compare to inservice provided in other areas?

8. Adaptable

Does your district have a mechanism by which program content and methodology are systematically reviewed and updated? _______

Comments:

(3) Interest and performance survey. The following survey can be used to complete the picture of status quo.(1) It provides an indication of interest as well as a subjective reading of performance. It is built on the Ten Sample Program Objectives listed in 4a. Each goal is covered in two items on the survey. If your district selects goals not listed in the Ten Sample Program Objectives, you will want to alter the survey accordingly.

The survey may be used with teachers, administrators, students, and health professionals. To bring the best response from teachers, the survey should be administered personally, and preferably in a group setting that would engender discussion of the items, and a sharing of current activites.

HEALTH EDUCATION INTEREST AND PERFORMANCE SURVEY

To plan Health Education activities to serve you best, we need your help! This survey lists 20 possible health education topics. Please respond to each item by indicating first how important you feel the topic is, then second, how well you feel the topic is being covered.

Name of School ____

Grade Level _________________________

DIRECTIONS: In the columns on the left, make an X in the box which best describes how important the topic is. In the column on the right, mark an X in the box which best describes to what degree you believe the topic is being covered. Mark a response in the left column and the right column for each of the 20 topics.

Below is an example of a topic which is very important but is only partially being covered.

Importance				Performance		
Little Imp.	Moderate Imp.	Very Imp.	Example	Not Being Covered	Partially Covered	Fully Covered
		X	1. Health careers		X	

Importance				Performance		
Little Imp.	Moderate Imp.	Very Imp.	Topic Area	Not Being Covered	Partially Covered	Fully Covered
			1. Learning about diseases (cancer, measles)			
			2. Preventing accidents on the roads and at home			
			3. Learning how to handle growing up			
			4. Understanding feelings and personality			
			5. Understanding drugs (including alcohol, tobacco, and prescription drugs)			
			6. Learning to cope with "hassles"			

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Importance				Performance		
Little Imp.	Moderate Imp.	Very Imp.	Topic Area	Not Being Covered	Partially Covered	Fully Covered
			7. Learning about the needs of yourself and other family members			
			8. Practicing basic first aid			
			9. Learning about health services and products			
			10. Personal care of the body			
			11. Understanding how families function			
			12. Learning to get the most from your health care dollar			
			13. Learning how environment affects your health			
			14. Learning what makes a healthy diet			
			15. Learning what to do about pollution			
			16. Practicing self-care and treatment of minor illness			
			17. Personal care of the body			
			18. Selecting physical fitness habits			
			19. Learning how to deal with alcohol/drug problems			
			20. Getting practice in food selection and preparation			

Name your own health topic ______________________________

____

Name your own health topic ______________________________

Name your own health topic ______________________________

Comments:

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Thank you!

The health status of students and staff provide a final indicator of the status quo of the program.

- what is the incidence of strep throat, or venereal disease?
- are there an unusual number of accidents in the school population?
- what is the incidence of alcohol/drug abuse?
- how is the personal interaction, mental health of the students and staff?
- are a lot of kids overweight or malnourished?

In reviewing health status pay particular attention to those problems that could be avoided or reduced through an active educational program.

4c. Statement of need. A comparison of Goals (where you want to be) and Status Quo (where you are) will provide a Statement of Need.

A formal comparison grid might be constructed to visually aid in the identification of areas of strength, areas of weakness, and priority areas of need. Below is a model of a comparison grid done for junior high.

SAMPLE GRID

HEALTH EDUCATION - STRENGTHS AND WEAKNESSES
GRADES 7-9

Topic	Interest Level	Current Program	Need Statement
Disease Control	High	Adequate - Covered in science and with school nurse	Moderate need

Topic	Interest Level	Current Program	Need Statement
Mental Health	High	Inadequate - both teachers and students expressed need to work on self-concept, understanding personality and peer pressure	High need
Growth/Development	Moderate	Excellent program - a major emphasis in life science. A favorite with students	Low need
Family Life	Moderate	Adequate program - Teachers expressed desire for more training, additional materials	Moderate need
Environmental Educ.	Moderate	Inadequate - A new topic Students interested but school is not geared up to the topic	Moderate need
Survival Skills	Moderate	Excellent program - safety and outdoor survival covered in Physical Education - available to all students	Low need
Alcohol/Drug Educ.	High	Adequate - Teachers felt materials and technique need to be updated	Moderate need
Consumer/Community	Moderate	Excellent program	Low need
Nutrition	Moderate	Excellent program - Classroom discussion done in conjunction with luncheon exercises	Low need
Personal Health Physical Fitness	Moderate	Adequate program - more emphasis needs to be given to personal skills	Moderate need

General comments:

Mental health and environmental health evolved as areas of highest need - followed by family living, alcohol/drug, and personal health. Interest was high among teachers, although there was concern about time for training and implementation.

4d. Explore alternatives. Two basic alternatives exist in developing a health education program:

(1) the review and adoption of an already existing, proven program in health education that meets the identified needs

(2) the development, from scratch, of a curriculum to meet identified needs.

In both instances, it is wise to review already existing programs, to avoid duplication of effort and to gather ideas about successful approaches that may be incorporated into any program. There are an increasing number of programs being developed at the local, state, and national levels. *The Department of Education maintains a resource list of districts within the state who have exemplary programs in health education.* Since the information on the list frequently changes, it is not included in this booklet, but can be obtained from the Department of Education.

After reviewing available programs, it is suggested that teams composed of a teacher, a parent, an administrator and school health person do a site visit to two or three programs. Below is a list of questions that should be asked when visiting another program.

SAMPLE SITE VISIT QUESTIONS

What is the professional preparation of the people who are teaching the program?

What type of workshops or inservices are necessary to teach the program effectively?

What are the written goals and objectives of the program?

How did they decide what was going to be taught?

What is the strongest feature of the program?

What are the things they would do differently?

What does the program cost to implement, including hidden costs such as curriculum writing, release time, inservice time, materials, etc.?

What evaluation mechanism do they have to show the program is effective?

How do the teachers feel about the program? (Talk to the teachers.) What do they see as the strong and weak points of the program?

Do they use the curriculum guide?

What is the level of parent involvement?

Do you see evidence of the program in the classroom/with the kids?

How do the students feel about it?

Is health integrated, or taught as a separate class?

What are the benefits and problems of their approach?

How long did it take them to implement the program?

What advice or other pointers do they have in developing a program?

5. Designating the program. Based on the exploration of alternatives, recommendations should be drawn up and presented to the School Board. It should include specifics on the following items:

- Overview of Survey findings - Major strengths and weaknesses of the current program, areas of high and low priority.
- Recommended program - basic features of alternative selected - why it was chosen
- Budget - itemize major categories such as personnel, inservice training, materials, etc.
- Time - specify time needed to develop, implement program
- Personnel - teachers and staff to be involved, assignments and time
- Timeline - when it will begin, where it will be piloted, when it will be reviewed and disseminated
- Evaluation - how it will be evaluated
- Reports - how you intend to keep them informed

On the basis of the information presented, the School Board will designate the plan to be adopted. They may further wish to designate a portion of the program to be approached first, since the entire program may be more detailed and expensive than what can be accomodated in a single year.

Program implementation is outlined in the following chapter.

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(1) Adapted from General Guidelines for School Health Education Curriculum Development, Intermediate School District 112, Washington State, Doug Goodlett, Editor, January, 1975.

CHAPTER XIII

PROGRAM DESIGN AND IMPLEMENTATION

This chapter will focus on the steps of program development which follow the designation of a health education program by the School Board. It contains an overview of program design and implementation, followed by a sample curriculum, and a more detailed presentation of resources in health education.

An Overview of Program Design and Implementation

The following is a summary of major steps in the program design and implementation process:

1. Formation of *curriculum development committee*.
2. *Preparation of curriculum guide* or appropriate program guide.
3. Design of *evaluation instruments* that will measure the effectiveness of the program.
4. *Identification of resources*. This includes resources for teacher training, as well as classroom speakers and materials.
5. Provision for adequate inservice for teachers, parents and other members of the staff.
6. *Pilot testing of the program* at one or two sites. *Evaluation* of the results of the pilot program and revision as indicated.
7. Pending the results of an evaluation, development of a *Master Plan* for dissemination and inservice.
8. Review and revision of program as appropriate, with reports at appropriate intervals to the School Board.

Detail of Program Design and Implementation

1. Formation of curriculum development committee. The most skilled and creative persons in the district should be tapped for this committee. The direction and excellence of the curriculum will depend on their expertise, energy, and creativity.

   It is particularly important that teachers are involved in the curriculum development process. They are the experts on the needs and interests of their grade level students, and it is they who will have ultimate responsibility for presenting the program in the classroom. Members of the health advisory committee and students may wish to work on curriculum development or at least be in touch with the progress that the committee is developing. In addition there may be community agencies who can provide input on specific aspects of the program such as cancer, mental health, and others.

2. Preparation of curriculum guide. If the decision of the School Board was to adopt an already existing health education program, the task of the curriculum committee becomes one of review, adaptation, and integration of the new units into the already existing school program.

   If there are no programs which meet district needs, the committee may want to consider the development of its own program or health curriculum. While this is a formidable task, it can also be a tremendous learning experience for teachers, students, administrators, and all others involved.

   There are health education guides produced by other districts, or commercially produced guides which may provide ideas on concepts, teaching activities and resources to the curriculum development committee. While no two communities have the same health needs many school districts have already been through the process of formulating a health program. While there is a great learning experience in writing a unit or health guide to fit local needs, much time and money is involved. There are many curriculum guides already designed. Most of them have already been tested in the classroom. These may well fit district identified goals and by adapting one or parts of several health programs to local needs the time and money saved might be spent on materials or inservice. A list of Colorado Curriculum Guides may be received from the Colorado Department of Education and others may be secured from other State Departments of Education.

   In designing activities, remember to include a variety of approaches such as factual information, decision-making processes, discussions and values clarification, and hands-on experiences.

There is no official state health education curriculum guide in Colorado. School districts are independent by law; the Department of Education does not mandate curriculum in any area. Each district has the responsibility for curriculum development and implementation.

The following pages contain a HEALTH CURRICULUM STARTER KIT, a sample of ideas around which a curriculum package can be built. The model is based on the Ten Sample Program Objectives listed in Chapter XII. The concepts and activities are a composite of ideas suggested in existing curriculum guides or by creative teachers in Colorado.

The Starter Kit is incomplete, with room for additional expansion and refinement. Each concept can be taught in a variety of ways limited only by the creativity of the teacher and the resources of the district.

THE *HEALTH CURRICULUM STARTER KIT* IS NOT INTENDED AS A STATE CURRICULUM GUIDE. IT IS MERELY A MODEL TO DEMONSTRATE SOME CONCEPTS AND ACTIVITIES THAT CAN BE INCLUDED IN HEALTH.

Program Objective: Disease Control

The student will identify various communicable and non-communicable diseases, their possible causes, prevention, and treatment. He will exhibit skill identifying treatment modes and initiating care.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° Germs may cause disease	° Do puppet show with Sneezy
° Our bodies help us fight disease	° Do flannelgraph of white blood cells as soldiers against germs as monsters
° Even small children can take certain actions to promote health	° Discuss with school nurse what to do when ill
° Parents, doctors and others can help us maintain good health	° Secure speaker - nurse or dentist to talk to children
4 - 6 Concepts:	
° Chronic disease may be inherited, caused by germs or by life-style	° Identify diseases by cause
° Certain chronic diseases may be prevented	° Discuss alternatives to prevent disease
° Everyone can take certain actions to control or prevent illness	° Identify specific things which children can do to promote health
7 - 9 Concepts:	
° The body has specific mechanisms to fight disease	° Discuss immune system of body
° The body may need help from outside chemical, biological or mechanical means to get well	° Secure speaker to discuss certain drugs or other aids
° Emotions affect our health and health affects our emotions	° Discuss psychosomatic disease - use stress and disease chart
10 - 12 Concepts:	
° Everyone is at risk of illness from chronic and communicable diseases	° Use life insurance or Heart Association personal risk chart
° Certain risks can be controlled through our choices of living habits	° Each student will be able to identify his/her particular risks and how to reduce them
° Actions of society or personal life style may affect the health of other people	° Discuss great plagues or food shortages
° Health behavior choices will continue throughout life	° Create personal alternative health behavior chart

Program Objective: Mental Health

The student will understand the forces which affect his or her mental health. He/she will develop the ability to cope with stress and to enjoy the pleasures of life.

Student will recognize that:	Teaching Activity
K-3 Concepts:	
° Each person is important	° Magic circle. Things I like best about me
° People are different from one another	° Pair off and compare likeness and differences (eye color, favorite hobby, etc.)
° Everyone has emotions	° An art project of 'Faces of Emotion'
° Differences between people can make the world more interesting	° Draw "same face" masks - have children add differences
4 - 6 Concepts:	
° We all depend on one another	° List things that you use in one day provided by someone else
° Emotions are affected by people and things	° Keep track on Wrist-tape of nice and hurtful comments during a day
° We can work together to make one another happier	° Give "warm fuzzies"
° Everyone has emotions	° See movie or filmstrip depicting emotions - have child draw emotions and share feelings
7 - 9 Concepts:	
° We all experience emotions and stress	° Share session, worry sheets
° Our emotions affect and are affected by others	° Isolation game
° We can work constructively with our negative emotions	° Pick one negative emotion and deal constructively with it
° We can work together to improve the health of all	° Positive sharing
10 - 12 Concepts:	
° There are varying degrees of mental stress	° Identify personal stress periods over the last three months
° Certain problem emotional stress situations may require outside help	° Student reports on resources
° We can work constructively to relieve undue stress	° Exercises to reduce stress and tension
° Stress can promote growth	° Discuss accomplishments that have been done under stress

Program Objective: Growth and Development

The student will understand and be prepared for different stages of physical and psychological development in himself/herself and his/her family members. He will exhibit skill in adjusting to these changes.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° Each person grows in a unique way	° Trace body outline
° The body has many parts that all work together	° Put in parts of body
° All living things grow and mature	° Hatch chicks and watch them grow
° Growth takes place in mental as well as physical ways	°
4 - 6 Concepts:	
° Growing and developing follows a predictable sequence; yet is unique for each individual	° Discuss baby pictures
° Everyone grows emotionally as well as physically	° Make emotion chart
° Each part of the body has unique functions and feelings	° Go through systems of the body and what it does
° Growth and development is influenced by heredity and environment	° Chart what things are hereditary and which are environmental
7 - 9 Concepts:	
° Growing and developing follows a predictable sequence; yet is unique	° Chart of family relations and friends on development
° Adolescence produces major physical and emotional changes	° Study of physical changes and scientific explanation
° Adolescence begins the process of more independent behavior	° List areas of growing responsibility
° Sexual development is pronounced in the adolescent	° Study reproductive system using excellent films available
10 - 12 Concepts:	
° Life is a series of changes and stages of development	° Interview someone five years older, ten years older
° Understanding these stages of development can help us cope with changes in ourselves and others	° Review what is known about phases
° Each person has responsibility for developing a values system to guide his/her continued growth	° Values clarification exercises

Program Objective: Family Living

The student will understand the roles and functions of families, and have sufficient knowledge to make wise decisions in this regard. He/she will demonstrate a knowledge of how to create a healthy environment for family members including children.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° All persons are members of some family	° Draw Families
° Family members have varying responsibilities and functions	° Star chart of responsibilities in classroom or home
° There are many forms of families	° Compare families from other cultures
4 - 6 Concepts:	
° There are many types of families	° Make a collage of families
° Family members affect one another	° Role reversals
° Families have certain functions in society	° Social studies unit on families from different lands
° Men and women are alike and different in many ways	° Discuss stereotypes
7 - 9 Concepts:	
° Family members influence personality and social development	° Films that illustrate
° There are societal customs relating to dating, love, and marriage	° Discuss customs, why and how families form
° Personal relationships carry rewards and responsibilities	°
° There are many kinds of love	° Identify and discuss different types of love
10 - 12 Concepts:	
° Families are a dynamic changing, growing unit	° Review danger signs of marriage
° Children have special needs; parents have needs	° Care for egg as a child for two weeks
° Understanding potential problem areas gives marriages a better chance of success	° Discuss danger signs of marriage disentegration
° Successful marriage requires understanding and constant work	° Communications exercises

Program Objective: Environmental Health

The student will develop an understanding of the relationship of environment and health. He/she will exhibit skills in making responsible decisions with regard to environmental health.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° All living things depend on one another	° Simplified chain of life
° Your health is affected by your environment	° Watch fish and how affected by light, clean or dirty water
° There are things you can do to preserve your environment	° Identify ways kids can help to preserve their environment i.e. water-use survey
4 - 6 Concepts:	
° All living things depend on one another	° Trace what happens to garbage
° Your environment can affect your health	° Sample water from ponds
° There are many things that pollute the environment	° Visit water treatment plant
° You can help protect your environment	° Take action based on garbage study
7 - 9 Concepts:	
° All living things depend on one another	° Discuss food chain ecosystem
° All people run varying health risks from environmental pollution	° Chart hazards in one day - compare urban and rural
° There are various things to do to make your environment safer	° Write letters supporting bike paths, etc.
° Increased population is a threat to the environment	° Secure and project statistics on city growth
10 - 12 Concepts:	
° Health is affected by environment	° Research noise pollution, etc.
° Environment can be improved through personal action	° Decide personal or class project to reduce health hazards at school
° Environment can be affected by individual action.	° Choose a pollution problem and investigate who has power to do what
° Action must be taken now to avoid future problems	° Promote a class project to enhance environment

Program Objective: Safety/First Aid

The student will be able to recognize potential hazards and understand how to prevent accidents. He/she will exhibit basic first aid skills.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° There are safety hazards all around	° Do hazard hunt with parents
° There are certain things to do to avoid accidents	° Do Halloween safety program, strangers, poisons, street-crossing, etc.
° There are people who can help in an emergency	° Practice emergency calls for help
4 - 6 Concepts:	
° Accidents are not always accidental	° School hazard hunt - bikes, swings, etc.
° Dangerous situations can be spotted and avoided	° Take findings to principal
° Basic first aid is essential in emergency situations	° Elementary first aid
° There are people who are trained to help in case of an emergency	° Practice more sophisticated calls for assistance
7 - 9 Concepts	
° Various environmental factors expose people to safety risks	° Experiment with temperature
° Appropriate clothing and procedures can help to avoid emergency situations	° Outdoor survival techniques
° Emotions affect actions/reactions in emergency situations	° Play emergency rummy
	° Basic first aid
10 - 12 Concepts	
° Any job and life style will expose us to risks	° Research accident hazards of jobs
° Appropriate training can reduce safety risks	° Driver education materials
° Appropriate first aid can save lives and reduce injury to others	° Advanced first aid

Program Objective: Alcohol/Drug

The student will understand the interrelationship of personal, chemical and environmental forces in the use and abuse of alcohol and other drugs. He/she will exhibit skills in coping with factors that influence alcohol/drug abuse.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° Having and expressing feelings is natural	° There are many excellent films on self-concept - Magic Circle to share feelings
° Warnings, danger signs and symbols are found on common household products	° Draw pictures of warning signs
° Advertising can produce an artificial feeling of need	° Compare cereals eaten by families and why they are chosen
4 - 6 Concepts:	
° There is an interdependency of the body systems and substances affect these body systems and their functioning	° Review knowledge of growth and development
° Peer pressure can be coped with	° Gain experience in decision-making and problem-solving
° A positive self-image may be developed by identifying sources of self-validation	° Identify things that make me feel good - form group activities
° Problems are part of everyone's life	° Develop skills to cope with problem situations
7 - 9 Concepts:	
° Each person's body possesses powers to alter mood	° Relaxation, deep breathing
° Personal actions carry responsibility or consequences	° Identify specific actions and consequences for self
° Critical analysis of advertising expands awareness of subtle techniques used to sell a product	° Analyze ads for drugs
10 - 12 Concepts:	
° Drug abuse affects a person's psychological, physiological, social and occupational well-being	° Student research, interviews reports
° Drugs have served many purposes throughout history	° Ivestigate various positive and negative social and historical influences of drugs
° There are methods of treatment and rehabilitation used to overcome drug dependency	° Examine current methods of treatment and rehabilitation by visiting a program

Program Objective: Consumer/Community

The student will possess sufficient understanding of health care services and products. He will exhibit skill in making wise choices concerning when, where, and how to seek care.

Student will recognize that:	Teaching Activity
K - 3 Concepts:	
° Advertising affects what we buy	° Have dentist talk about different toothpastes
° Safety precautions must be taken with medicines	° Discuss who we should listen to about medicine
° We have responsibility to help others	° Class make up rules for good health
4 - 6 Concepts:	
° Not everything you hear about products is true	° Have children make up mythical health cures and sales pitch them
° Each person can choose health products and services wisely	° Identify choices children have
° Labels have much useful information	° Analyze labels
7 - 9 Concepts:	
° It is the individual's responsibility to evaluate health information and services	° Read labels of acne cream, fad foods, etc.
° Advertising can influence our decisions in selecting health care	° Analyze ads for health products
° Knowledge makes you a better consumer	° Study common terms used by doctors and dentists
° There is much overuse of medicine	° Discuss differences of prescription drugs vs. over-the-counter drugs
° Cosmetics can only do so much	° Secure speaker to discuss teen-age cosmetics
10 - 12 Concepts:	
° Some illnesses/conditions require outside help	° Take one problem - research resources
° Health consumers have rights	° Have class compose their rights and responsibilities as adult health consumers
° Careful selection of health products and services can save money	° Research cost of care - keep track of family need expenses
° There are alternative systems of health care	° Interview elderly as to how they took care of illness - Critically review another system of care

Program Objective: Nutrition

The student will understand what constitutes a proper diet. He will exhibit skills in selecting and preparing a proper diet for himself and family.

Student will recognize:	Teaching Activity
K - 3 Concepts:	
° Foods contain substances for growth, energy and health	° Construct body - Milk = bones; Meat = muscles group
° Food can be divided into four food groups to help us decide what we should eat to grow up healthy	° Make "Stone Soup" with each child assigned one food
° People in different cultures eat different foods	° Tasting party
° There are many sources for the four food groups	° Draw pictures of members of meat group, etc.
4 - 6 Concepts:	
° Culture influences our food choices	° Compare family food habits
° Nutrients have specific functions in our body	° Experiments in science
° You are what you eat	° Collage of what that person ate last week in human form
° Some foods are more healthful; some harmful	° Discuss snack foods, fads
7 - 9 Concepts:	
° Nutrition affects appearance and mental health	° Keep record of food intake and energy
° We all have different nutritional needs	° Calculate exercise, weight, etc.
° Food selection and eating fill psychological needs	° Have experiments in eating alone
° Weight is controlled by eating and exercise	° Calculate exercise/calorie ratio
10 - 12 Concepts:	
° Special conditions may require special diets	° Review a special diet
° Our individual and societal actions can influence food production and consumption around the world	° Research world food patterns
° Food preparation and serving affects our diets	° Study ways to make eating attractive. Make meal plans for times when complete meals are impractical

Program Objective: Personal Health/Fitness

The student will understand proper care of parts of the body including care of teeth and the senses. He will understand the role of fitness to overall health and exhibit skills in selecting personal health and fitness practices.

Student will recognize:	Teaching Activity
K - 3 Concepts:	
° Rest gives the body time for repair	° Do relaxation exercises
° Our senses and teeth need special care	° Nurse to discuss eye, ear, tooth care - Experiment in talking without touching teeth
° Keeping clean can help a person to be healthy by avoiding disease	° Discuss "dirty dirt vs clean dirt"
° Some physical activities promote health others detract	° Do bending, stretching - Discuss harmful physical activities
4 - 6 Concepts:	
° Specific exercises do specific things to your body	° Specific exercises to improve flexibility, endurance, etc.
° Culture, peer pressure affect our exercise and fitness habits	° Discuss social barriers to exercise and how to overcome them
° Physical changes in adolescence require special exercise and health habits	° Chart to explain special needs of adolescence
° Rest is not always sleep	° Practice relaxation exercises
° One can learn to preserve teeth	° Practice flossing, etc.
7 - 9 Concepts:	
° Exercise affects emotions and appearance	° Personal record chart
° We all have different exercise needs and capabilities	° Do calculations on exercise and necessary food intake
° Emotions, culture help determine our exercise habits	° Interview adults about exercise, why they do or don't
° A balance of exercise, rest, nutrition are necessary to healthful living	° Take fitness test
10 - 12 Concepts:	
° Nutritional needs change throughout life	° Review needs of children, adolescents
° Special conditions may require special exercise	° Therapist to discuss exercises for sore muscles, elderly, etc.
° We may help others to better fitness	° Dental project with elementary
° Relaxation is essential to good health	° Discuss various forms of yoga, etc.

Incorporating Health Concepts Into the Curriculum. Once health concepts have been identified, the task remains of designing teaching units and developing lesson plans that can make the concepts come alive in the classroom. The following pages contain sample lesson plans which illustrate ways in which concepts or program objectives have been turned into creative teaching units. The development of these teaching units is essential to the implementation of the program.

The placement of health education units in the curriculum will depend upon the curriculum structure and personnel available within a particcular district. It is recommended at the national level that one semester of health education be included at the junior and senior high level. Many of the larger districts in Colorado offer separate health education classes taught by teachers endorsed in health education. This simplifies curriculum development, coordination, evaluation, and program revision. It reduces the chances of duplication or omission of important concepts.

In districts with more limited curriculum offerings, health education is frequently integrated into the curriculum. This is accomplished by a mix-and-match procedure in which health concepts are identified and assigned to an allied curriculum area such as science, home economics, physical education.

The integrated approach has the advantage of requiring no new staff members; however, it does multiply the number of people who will need to be inserviced in their particular segment of the curriculum. Integration shows the interrelationship of health to other areas of learning concepts in all areas of education. It does increase the work of the coordinator to assure that all concepts are indeed being covered in a suitable manner.

With few exceptions, health education at the elementary level is integrated into the curriculum. Exercises aimed at improving writing skills can use safety rules as the topic; children can improve reading skills by reading about steps to take in treatment of an illness; a comparison of height and weight can be done in conjunction with a unit in metric measurements. The nutrition lesson on the following pages is designed to give nutrition information while enhancing basic skills.

The information on the following pages is reprinted with permission from the National Dairy Council.

ACTIVITY 10

STUDYING FOOD PROBLEMS WORLDWIDE

Understanding the differences in food supplies around the world

Background and Purpose:

This activity enables students to explain several factors that influence the world food supply. As students gain insights into the world food situation, they may be encouraged to identify ways to use food more efficiently.

It is estimated that nearly 15 percent of the world's population lives in developed countries, where most people have enough money, schooling, and food. Approximately 85 percent of the world's population lives in developing countries where many people are poor and hungry. Many of these developing countries are located in Asia, Africa, and Latin America. Nutrient deficiencies resulting from a lack of food are found in these countries. Several factors that have contributed to the world food shortage are:

—Increased world population due to increased lifespan but no decrease in the birth rate
—Devaluation of the dollar and inflation
—Inefficient agriculture
—Poor weather
—Increased price of oil

In studying the world food supply, students are reminded that a new source of food is the result of fabrication. Fabricated foods are sometimes called formulated or engineered foods.
It is important to note that fabricated foods alone are not expected to solve the world food situation.

Fabricated, formulated, or engineered foods are foods put together in a new way. An example, CSM, has been fabricated to help fulfill nutrient needs of people in developing countries. CSM is a mixture of cornmeal, soy flour, nonfat dry milk, vitamins, and minerals. This mixture is shipped by the United States, UNICEF, and other agencies to more than 100 developing countries. The taste of CSM is bland, so it can be used as an ingredient in several foods without changing the taste. The supply and formulation of CSM vary with crop surpluses.

Many fabricated foods are available in local supermarkets. Examples include meat analogs that use vegetable protein made to resemble meat and egg analogs that resemble eggs but use other ingredients.

PART A: ENOUGH FOR EVERYONE

Estimated time—30 minutes

Materials:

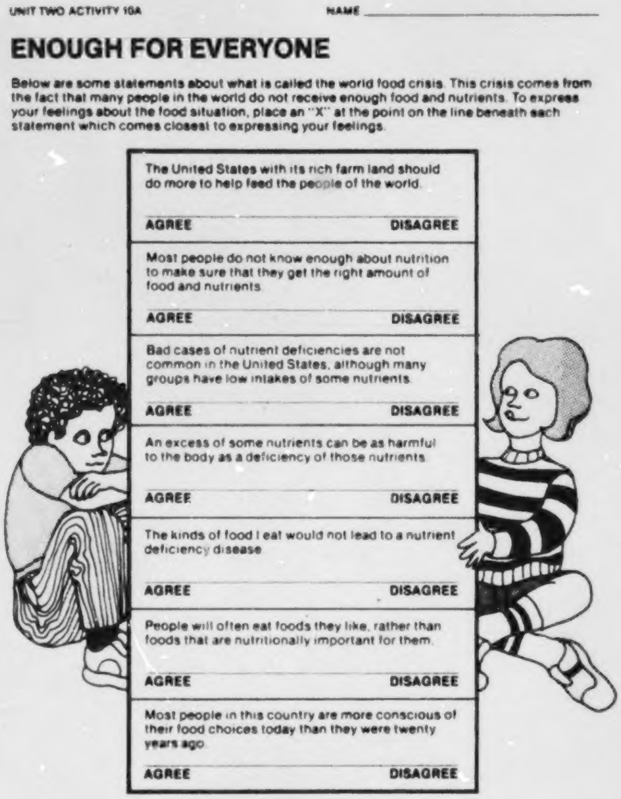
SAS 10A—*Enough for Everyone*
World map
Encyclopedias

Procedure:

1. Have each student locate one country in Asia, Africa, and Latin America.
2. Ask the students to describe the food supply for each country. Students should gather sufficient information from resource books to determine if a food shortage exists in each country.
3. If a food shortage exists, ask students to find out what actions are being taken to make more food available. *Government land reform, better use of land and water, more efficient animal agriculture, improved plants, education, home gardening, high cost of energy.*
4. Inform the class that many groups are aiding the world's hungry. An example is the:
   United Nations Children's Fund (UNICEF)
   331 East 38th Street
   New York, New York 10016

   The teacher may choose to have students write to UNICEF for additional information on the world food shortage.
5. Have students report to the class on the food supply in the country they have been studying.
6. Distribute SAS 10A. Have students complete the activity sheet at home. Ask students to explain the world food situation to their families and see if their families can suggest food conservation practices to use in their own homes.
7. Discuss the completed activity sheet with the class. Summarize the results by recording the number of "agrees" and "disagrees" for each statement.
8. In summarizing, encourage students to express their feelings about the world food situation. The teacher may wish to have the students share their suggestions for curbing waste at home.

9. Have students suggest ways to curb waste at school. The teacher may choose to share these suggestions with the school foodservice manager. Encourage students to implement their suggestions for food conservation at home and in school.



UNIT TWO ACTIVITY 10A NAME ______________________

ENOUGH FOR EVERYONE

Below are some statements about what is called the world food crisis. This crisis comes from the fact that many people in the world do not receive enough food and nutrients. To express your feelings about the food situation, place an "X" at the point on the line beneath each statement which comes closest to expressing your feelings.

The United States with its rich farm land should do more to help feed the people of the world.

AGREE ______________________ **DISAGREE**

Most people do not know enough about nutrition to make sure that they get the right amount of food and nutrients.

AGREE ______________________ **DISAGREE**

Bad cases of nutrient deficiencies are not common in the United States, although many groups have low intakes of some nutrients.

AGREE ______________________ **DISAGREE**

An excess of some nutrients can be as harmful to the body as a deficiency of those nutrients.

AGREE ______________________ **DISAGREE**

The kinds of food I eat would not lead to a nutrient deficiency disease.

AGREE ______________________ **DISAGREE**

People will often eat foods they like, rather than foods that are nutritionally important for them.

AGREE ______________________ **DISAGREE**

Most people in this country are more conscious of their food choices today than they were twenty years ago.

AGREE ______________________ **DISAGREE**

Part B: Fabricated or Traditional ●

Estimated time—45 minutes

Materials:

SAS 10B—*Fabricated or Traditional*
Samples of fabricated foods
Samples of traditional foods

Procedure:

1. Remind students that they have been discussing the world shortage of food and that one attempt to find new sources of food is through fabricated foods.
2. Ask the students to define or identify a fabricated food.
3. Ask students to name any fabricated foods that they have seen or tasted.
4. Show the students the samples of fabricated foods that have been assembled. Associate the fabricated food with its traditional counterpart.
5. Ask students to name the advantages and disadvantages of fabricated foods.

Advantages:
—Convenience
—Fabrication to meet special health needs
—Cost may be reduced
—They can be filling or satisfying
—They can make use of new sources to increase our food supply.

Disadvantages:
—Might be lacking some nutrients and fiber present in traditional foods
—Might contain high amounts of nutrients not present in traditional foods
—Might not be as tasty
—Might cost more and might require more energy to produce.

6. Explain to the students that the class will be comparing and contrasting fabricated and traditional foods at a tasting party.
7. ● Distribute SAS 10B to the students. Arrange the class in small groups for the tasting party. Remind the students that they should complete all sections of the activity sheet. Encourage the students to try the unfamiliar foods.
8. After the tasting party ask students to discuss their reactions with one another.
9. ● Ask students to find out what fabricated foods are sold in the local supermarkets. Have students make a list of these foods and identify several uses for the fabricated foods.
10. Summarize this part of Activity 10 by having students write a paragraph on how food technology influences our food supply.

Supplementary Resources:

From National Dairy Council:
Food News-World Food Situation
This issue summarizes events such as the Russian grain buy and increase in oil prices that ushered in the global food shortage. Shorter articles cover grains, gardening, and garbage.

From the library:
Helfman, Elizabeth S. 1970. *This Hungry World.* New York: Lothrop, Lee & Shepard Co.

Hellman, Hal. 1972. *Feeding the World of the Future.* New York: M. Evans and Company, Inc.

Pringle, Lourence. 1975. *Chains, Webs, and Pyramids: The Flow of Energy in Nature.* New York: Thomas Y. Crowell Company.

● Indicates advance preparation for the teacher

INTERDISCIPLINARY CONTENT

Correlations with Other Subjects

Activities	Math	Language Arts	Science	Social Studies	Arts	Health	Food Preparation
1 Clarifying Our Values		X		X			X
2 Naming Factors That Influence Food Choices		X		X			
3 Analyzing Advertising Appeals		X		X			
4 Introducing Nutrients, Functions, and Food Sources		X	X			X	
5 Focusing on the Human Fuel System		X	X			X	X
6 Investigating Energy	X		X			X	
7 Hunting for Nutrition Information	X			X			
8 Classifying *Comparison Cards*	X	X			X		X
9 Scoring the Servings	X		X			X	
10 Experimenting with Food	X		X			X	X
11 Looking at Breakfast and Lunch	X	X	X			X	
12 Controlling the Snacks	X		X			X	X
13 Planning and Supporting a Day's Intake	X	X	X			X	
14 Publicizing Food	X	X	X	X	X	X	

3. Design of evaluation instruments. The purpose of evaluation is to provide the teacher, the student, and the administration with information concerning the effectiveness of a particular educational approach. It is not intended as a personal evaluation of individuals in the program, but rather an assessment of how effective the selected methods and educational activities are in reaching the goals which have been set. In the area of alcohol/drug education, evaluation has helped eliminate ineffective methods such as scare tactics and has pointed the way to such techniques as values clarification. If properly designed, evaluation plans can become precision teaching tools.

Criteria and procedures for evaluating the effectiveness of a program need to be established before a program is begun. Anyone who will be doing the evaluation, or using the results should be involved in its design. The following pages contain a Sample Evaluation Plan. The K-3 Disease Control Unit and the 7-9 Safety and First Aid Unit are given as examples. They are based on the Program Objectives and Teaching Activities referred to earlier in this chapter. A complete evaluation would contain similar plans for each program objective, at each grade level.

To chart the progress of the individual student with regard to health knowledge and behavior, simply add the student's name and a fourth column to indicate the results of testing (see Student Health Skills Index). The sample illustrates skills in the area of Safety/First Aid. A similar index would need to be made up for each program objective.

Long range evaluation needs to be developed to test the retention of knowledge and skills. These evaluations are extensive and must be tailored to meet specific district needs and resources. You may contact the Department of Education for individual assistance in this matter.

SAMPLE EVALUATION PLAN

Program Objective: Disease Control

The student will identify various communicable and non-communicable diseases, their possible causes, prevention, and treatment. He will exhibit skill identifying treatment modes and initiating care.

Student will recognize that:

K - 3 Concepts:	Method of Evaluating	Criteria of Success
° Germs cause disease	° Understanding - Student will be able to explain through paper and pencil test how colds are spread ° Behavior - Students will cover noses when they sneeze	° 70 percent accuracy
° Our bodies help us fight disease	° Understanding - Student will be able to take an example of any given communicable disease and in an oral exam, explain the basic elements of how our body fights disease	° High degree of accuracy in explanation
° Even small children can take certain actions to promote health	° Understanding - Student will be able to select on a mutliple choice exam appropriate treatment for simple illnesses including a minor cold and a stomach ache ° Behavior - Students will take appropriate care of illness	° Appropriateness of recommendations
° Parents, doctors and others can help us maintain good health	° Understanding - Paper and pencil test of what doctors and parents and others can do to help	° High degree of accuracy

SAMPLE EVALUATION PLAN

Program Objective: Safety/First Aid

The student will be able to recognize potential hazards and understand how to prevent accidents. He/she will exhibit basic first aid skills.

Student will recognize that:

7 - 9 Concepts:	Method of Evaluating	Criteria of Success
° Various environmental factors expose us to safety risks	° Understanding - Written test on bodily needs in survival situations ° Behavior - Teacher will observe if student dresses appropriately for weather	° 70 percent accuracy on test
° Appropriate clothing and procedures can save us from serious injury or death	° Understanding - Student will list on written exam various items of clothing and their usefulness in a survival situation ° Behavior - Student will pack a survival kit for an automobile	° 70 percent accuracy Kit contains all elements for survival
° Emotions can affect our actions and reactions in emergency situations	° Understanding - In detailing what to do in an emergency, the student will include recommendations on how to handle fear, etc., (written test) ° Behavior - Student will respond appropriately in simulated emergency situations	° Inclusion of emotional concerns in story; accuracy of recommendations

SAMPLE STUDENT HEALTH SKILLS INDEX

John Doe
Grade 8 - School: Rocky Road Junior High School

Program Objective: Safety/First Aid

The student will be able to recognize potential hazards and understand how to prevent accidents. He/she will exhibit basic first aid skills.

Student will recognize that:

7 - 9 Concepts:	Method of Evaluating	Criteria of Success	Date Evaluated
• Various environmental factors expose us to safety risks	• Understanding - Written test on bodily needs in survival situations • Behavior - Teacher will observe if student dresses appropriately for weather	• 70 percent accuracy on test	• 11/24 - Excellent
• Appropriate clothing and procedures can save us from serious injury or death	• Understanding - Student will list on written exam various items of clothing and their usefulness in a survival situation • Behavior - Student will pack a survival kit for an automobile	• 70 percent accuracy Kit contains all elements for survival	• 12/16 - packed kit perfectly
• Emotions can affect our actions and reactions in emergency situations	• Understanding - In detailing what to do in an emergency, the student will include recommendations on how to handle fear, etc., (written test) • Behavior - Student will respond appropriately in simulated emergency situations	• Inclusion of emotional concerns in story; accuracy of recommendations	• 2/7 - good understanding of effects of fear

4. Identification of Resources. The concepts and activities outlined in the previous pages can be greatly enhanced by adequate materials and resources. Appropriate films, models, and discussion sheets stimulate student interest and facilitate the teaching of particular health units.

Each designated teaching activity should be reviewed to determine the materials necessary to carry it out in the classroom. An itemized list of the necessary materials, including their cost, should be presented to the administration for inclusion in budget requests. Teachers should have the opportunity to review materials and designate those which they wish to have placed on the budget list. A review of new materials should be scheduled on a regular basis.

Health teachers are fortunate in having additional sources of classroom materials available to them. A number of agencies are willing to provide materials, teacher inservices and program development assistance in their particular area of interest. For example, the Rocky Mountain Poison Center will provide classroom presentations, teacher training, and limited classroom materials in poison prevention.

Once materials are received, they should be inventoried or placed in a resource center to avoid loss or duplication of requests. A list of available materials should be circulated to increase use of the items.

The following pages include a sample letter which can be adapted to request materials from resource agencies and a list of in-state and out-of-state resource agencies

SAMPLE MATERIALS REQUEST LETTER

American Foundation for the Blind
15 West 16 Street
New York, New York 10011

Dear Sirs:

I am a sixth grade teacher at Rocky Road Elementary School in Beautiful View, Colorado. I am planning a unit on blindness and would like to receive 30 copies of any free educational materials appropriate to this grade level. I would also like any free reference materials that you could send me for my own information.

If there is a charge for your materials, I would appreciate receiving a catalog and sample materials for examination.

Please send the materials to:

Thank you for your assistance and prompt attention to this request.

Sincerely,

COLORADO RESOURCES IN HEALTH EDUCATION

Resource	Topic Area	Grade Level	Type of Service	Fee for Service
Alcoholism Council of Colorado 2727 Bryant St., Suite 310 Denver, Colorado 80211 Telephone: 458-0130	Alcohol use and abuse	K-12, Adult	Teacher inservice, teacher workshops, Pilot youth program	Nominal or none
American Automobile Association 4100 East Arkansas Avenue Denver, Colorado 80222 Telephone: 753-8840	Pedestrian and bicycle safety, school safety patrol	K-12, Adult	Films, Pamphlets, Teacher guides, Student booklets, Assembly program--a magician incorporating the rules of pedestrian and bicycle safety	Free loan on some films, nominal fee on expendable student materials
American Cancer Society Colorado Division 1809 E. 18th Avenue Denver, Colorado 80218 Telephone: 321-2464	Cancer, Smoking	K-12, Adult	Extensive pamphlets, Films, other audio-visual materials, posters, lesson kits, classroom speakers, teacher inservice, assistance to district in developing cancer education and anti-smoking units	None
American Lung Association 1600 Race Street Denver, Colorado 80206 Telephone: 388-4327	Lung disease, Exclusive of cancer	K-12, Adult	Films, pamphlets, classroom speakers, teacher inservice	None
American Red Cross, Denver Region 1700 Steele Denver, Colorado 80206 Telephone: 399-0550	Nursing and Health, First aid, water safety	K-12, Adult	Films, pamphlets, classroom instructional program in safety, health, leadership, teacher inservice, teacher workshops in first aid and safety	Minimal charge for teacher workshops, books and expendables
Arthritis Foundation, Rocky Mountain Chapter 70 West Sixth Avenue Denver, Colorado 80204 Telephone: 623-5191	Arthritis	Junior high upwards	A Film, pamphlets, classroom speakers, teacher inservice	None
Blue Cross Blue Shield 700 Broadway Denver, Colorado 80203 Telephone: 831-2131, Extension: Public Affairs Div.	General health topics, Stress, Physical fitness, Drug abuse	Junior high, High School, Adult	Film on alcoholism, booklets, classroom speakers	Free loan on one film-first 100 booklets free.

Resource	Topic Area	Grade Level	Type of Service	Fee for Service
Colorado Department of Education Health and Survival/Alcohol/Drug Program 201 East Colfax Ave., Room 507 Denver, Colorado 80203 Telephone: 892-2241	Health education, Alcohol/drug education	K-12	Assistance in program development, assistance in identification of resources, materials, teacher training, technical assistance upon request	None
Colorado Department of Education School Food Services 201 East Colfax Ave., Room 318 Denver, Colorado 80203 Telephone: 892-2217	Nutrition education	K-12	Films, posters, pamphlets, teacher training, technical assistance to teachers, districts	None
Colorado Department of Health 4210 East 11th Avenue Denver, Colorado 80220 Telephone: 388-6111	Dental health, Poison control, Maternal and child health, Communicable disease	K-12, Adult	Films, slide programs, pamphlets, classroom speakers, teacher inservice	None
Colorado Health Careers Council 1601 East Nineteenth Avenue Denver, Colorado 80218 Telephone: 534-8580	Accredited training programs for health careers	Students, Adults, Educators, Counselors, Librarians	Quick reference guide, general information booklet, scholarship and loans book, individual write-ups on 100+ professions (need specific requests), exhibits, speakers, informational material and handout flyers to medical fairs, school career days, etc., help in arranging tours of health care facilities, loan of visual aids, speaker bureau, desk file or packets with career write-ups to be purchased	Nominal or none
Colorado Heart Association 4521 East Virginia Denver, Colorado 80222 Telephone: 399-2131	Cardiovascular Disease	3rd grade, upwards	Films, pamphlets, classroom speakers, teacher inservice	Free loan on films, nominal fee on pamphlets in quantity over 10
Colorado Safety Association Suite 200, Ross Building 1726 Champa Street Denver, Colorado 80202 Telephone: 222-2623	All aspects of safety	K-12, Adult	Films, slide programs, pamphlets, collection of books on safety topics	To schools: no charge on films, nominal charge on pamphlets, free loan on books

Resource	Topic Area	Grade Level	Type of Service	Fee for Service
Colorado State University Extension Service Health Education Specialist Fort Collins, Colorado 80523 Telephone: 491-6281	Nutrition, safety, child development, consumer science	K-12, Adult	Films, slide programs, pamphlets and fact sheets, classroom speakers, teacher inservice	None
Colorado PTA - PTSA 3460 West 38th Avenue Denver, Colorado 80211 Telephone: 458-1210	Parenting education, venereal disease, children's emotional health	Most material geared for adults	Films, pamphlets, classroom speakers, teacher inservice	Nominal charge on pamphlets, schools requesting materials should have PTA
Colorado Society for the Prevention of Blindness 3506 East Twelth Avenue Denver, Colorado 80206 Telephone: 399-8090	Eye health and eye safety	K-12, Adult	Films, pamphlets, classroom speakers, teacher inservice, student vision screening	None
Consumer Information Center Pueblo, Colorado 81009	Consumer issues	High school, Adult	Provides catalog of selected federal publications of consumer interest -- many in health areas (diet, vitamins, medical quackery, mental health services, etc.)	Catalog free, pamphlets free or at low cost
Consumer Product Safety Commission 817 17th St., Suite 938 Denver, Colorado 80202 Telephone: 837-2904	Product safety (toys, bicycles, poisonous substances)	K-12, Adult	Films, slide programs, extensive pamphlets, posters, teacher guides, classroom speakers, teacher inservice	None
Dairy Council of Colorado 12450 N. Washington Street Thornton, Colorado 80421 Telephone: 451-7711	Nutrition education	K-12, Adult	Films, slide programs, posters, transparencies, abundant audio-visuals, student booklets, pamphlets, newsletters, teacher workshops	No fee for workshops, free or nominal fee on pamphlets, $5-$8 slide cassette programs, free loan on films
Division of Highway Safety Colorado State Government 4201 East Arkansas Avenue Denver, Colorado 80222 Telephone: 757-9481	Traffic safety, alcohol abuse	Junior high, High school, Adult	Films, pamphlets, classroom speakers, teacher inservice	None

Resource	Topic Area	Grade Level	Type of Service	Fee for Service
March of Dimes Regional Office 8000 East Girard Avenue Denver, Colorado 80231 Telephone: 750-2010	Prenatal care, birth defects	K-12, Adult	Films, slideshows, pamphlets, classroom speakers, teacher inservice	None
Mental Health Association of Colorado 1001 Jasmine Street Denver, Colorado 80220 Telephone: 355-1672	Mental health	High school, Adult	Films, slide program, pamphlets, classroom speakers, teacher inservice	Nominal fee for pamphlets, free loan on films and slide presentations, usually n fee for speakers
Metropolitan Denver District Attorney's Consumer Office 655 South Broadway Denver, Colorado 80209 Telephone:	Consumer protection	Junior high, upwards	Some audiovisual materials on general consumer issues, classroom speakers available for certain counties, teacher inservice, consumer center library	None
Metropolitan Life Insurance Company 10190 Montview Blvd. Denver, Colorado 80010 Telephone:	General health topics, safety, stress	High school, Adult	Films (through national office), pamphlets	None
National Center for the Prevention and Treatment of Child Abuse & Neglect 1205 Oneida Street Denver, Colorado 80220 Telephone: 321-3963	Child abuse and neglect	Adult	Referrals for resources for reporting child abuse and neglect and for studying child abuse and neglect, newsletter on child abuse and neglect which also offers listed resources for parenting education, teacher inservice (limited to Denver area) on recognizing and reporting child abuse and neglect	None
National Council of Alcoholism Mile High Area 2727 Bryant St., Suite 310 Denver, Colorado 80211 Telephone: 455-4168	Alcohol abuse	Junior high, upwards	Films, pamphlets, classroom speakers, teacher inservice	$1 charge on films, no charge for speaker or for limited quantities of literature

Resource	Topic Area	Grade Level	Type of Service	Fee for Service
Public Service Company of Colorado Information Department P. O. Box 840 Denver, Colorado 80201 Telephone: 571-7713	Electrical safety	K-12, Adult	Films, comic books, pamphlets, classroom speakers, teacher inservice	None
Rocky Mountain Planned Parenthood Administrative Office 2030 East 20th Avenue Denver, Colorado 80205 Telephone: 388-4215	Family planning, sex education, parenting education	All ages	Films, pamphlets, booklets, classroom speakers, teacher inservice, teacher workshops (sex education, parenting, adolescents' problems)	$3-$5 in Denver, fee for films, outside Denver $10, nominal fee for classroom speakers, fee for inservice and workshops varies
Rocky Mountain Poison Center West 8th and Cherokee Denver, Colorado 80204 Telephone: 629-1123	Poisoning	Focus on ages 3-7 & Adults	Films, slide programs, fact sheets, Officer Ugg stickers, comic books, classroom speakers, teacher inservice	$10 fee for films, no fee for materials (limited quantities)
Safeco Insurance Company P. O. Box 5687 Denver, Colorado Telephone:	Outdoor safety	Junior high upwards	Films on ski safety, bicycle safety, exposure to the elements	Free loan on films
Tri-County Health Department 4857 South Broadway Denver, Colorado Telephone: 761-1340	General health education	K-12	Teacher inservice, films, materials	None
U. S. Food and Drug Administration Room 500 U. S. Custom House Denver, Colorado 80202	Consumer health	Junior high upwards	Films, pamphlets, fact sheets, speakers for assemblies, teacher inservice, teachers' mini-lesson plans, assistance to individual schools in setting up programs in consumer health	None

OUT OF STATE RESOURCES*

The following is a list of agencies that provide education materials in health education. Some of the agencies are commercial concerns; others will provide materials either free or at a nominal fee. The information listed is accurate as of August 1977, and is subject to change.

> The listing of a resource in this guide does not constitute an endorsement of **the teaching materials or associated products.**

Abbott Laboraties
14th and Sheridan Road
North Chicago, Illinois 60064

Aetna Life Insurance Co.
151 Farmington Avenue
Hartford, Connecticut 06115

Agency for Instructional Television
Box A
Bloomington, Indiana 47401

Alberto-Culver Company
2525 Armitage Avenue
Melrose Park, Illinois 60160

Allergy Foundation of America
801 Second Avenue
New York, N.Y. 10017

American Alliance for Health, Physical
Ed., and Recreation
1201 16th Street, N.W.
Washington, D.C. 20036

American Academy of Pediatrics
P.O. Box 1034
Evanston, Illinois 60204

American Association of Ophthalmology
1100 17th Street, N.W.
Washington, D.C. 20036

American Can Company
230 Park Avenue
New York, N.Y. 10017

American Cancer Society
219 East 42nd Street
New York, N.Y. 10017

American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611

American Diabetes Association, Inc.
1 West 48th Street
New York, N.Y. 10020

The American Dietetic Association
430 N. Michigan Avenue
Chicago, Illinois 60611

American Dry Milk Institute, Inc.
130 North Franklin Street
Chicago, Illinois 60606

American Foundation for the Blind
15 W. 16th Street
New York, N.Y. 10011

American Heart Association
44 East 23rd Street
New York, N.Y. 10010

American Home Economics Association
1600 20th Street, N.W.
Washington, D.C. 20009

American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

American Institute of Baking
Consumer Service Department
400 East Ontario Street
Chicago, Illinois 60611

The American Institute of Family Relations
5287 Sunset Boulevard
Los Angeles, California 90027

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*Adapted from a Resource List prepared by Michael Jones, Fort Morgan School District.

American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

American National Red Cross
17th and D Streets, N.W.
Washington, D.C. 20006

American Optometric Association
7000 Chippewa Street
St. Louis, Missouri 63119

American School Health Association
Kent, Ohio 44240

American Social Health Association
260 Sheridan Avenue
Palo Alto, California 94306

Arthritis and Rheumatism Foundation
1212 Avenue of the Americas
New York, N.Y. 10036

Associated Press
291 Broadway
New York, N.Y. 10007

Audio Visual Narrative Arts, Inc.
P.O. Box 9
Pleasantville, N.Y. 10570

BFA Educational Media
CBS Educational Publishing
2211 Michigan Avenue
P.O. Box 1795
Santa Monica, California 90406

Block Drug Corporation
Professional Relations Division
105 Academy Street
Jersey City, N.J. 07302

Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario, Canada KLG 3Y6

Center for Disease Control
Technical Information Services
Bureau of State Services
Atlanta, Georgia 30333

Channing L. Bete Company, Inc.
45 Federal Street
Greenfield, Massachusetts 01301

Chicago Dietetic Supply, Inc.
405 East Shawmut Avenue
LaGrange, Illinois 60625

Childrens Press
1225 West Van Buren Street
Chicago, Illinois 60607

Connecticut General Life Insurance Co.
Hartford, Connecticut 06152

Cystic Fibrosis Foundation
3379 Peachtree Road, N.E.
Atlanta, Georgia 30326

DO IT NOW FOUNDATION
National Media Center
P.O. Box 5115
Phoenix, Arizona 84010

Eli Lilly and Company
Indianapolis, Indiana 46206

The EMKO Company
7912 Manchester Avenue
St. Louis, Missouri 63143

Encyclopedia Britannica Films, Inc.
5625 Hollywood Boulevard
Hollywood, California 90028
or: 5288 Foothills Boulevard
Oakland, California 94601

Energy Fuels Corporation
Executive Offices, Suite 445
Three Park Central
1515 Arapahoe
Denver, Colorado 80202

E & R Development Company
A Division of Hertzberg-New Method
Vandalea Road
Jacksonville, Illinois 60607

Follet Publishing Company
1010 West Washington Boulevard
Chicago, Illinois 60607

General Foods Consumer Center
250 N. Street
White Plains, N.Y. 10625

General Mills
Consumer Center
P.O. Box 1113
Minneapolis, Minnesota 55440

Guidance Associates
757 Third Avenue
New York, N.Y. 10017

Harcourt Brace Jovanovich, Inc.
Saddle Brook, New Jersey 07662

The Hogg Foundation for Mental Health
The University of Texas
Austin, Texas 78712

Household Finance Corporation
Prudential Plaza
Chicago, Illinois 60601

Household Finance
Corporation of Canada
85 Bloor Street East
Toronto, Ontario M4W 1B4

Joint Council on Economic Education
1212 Avenues of the Americas
New York, N.Y. 10036

Kellog Company
Department of Home Economics Services
Battle Creek, Michigan 49016

Kimberly-Clark Corporation
Educational Department
Life Cycle Center
Neenah, Wisconsin 54956

Laidlaw Brothers
Thatcher and Madison
River Forest, Illinois 60305

Mental Health Film Board
166 East 38th Street
New York, N.Y. 10016

Media Materials, Inc.
2936 Remington Avenue
Dept. 765432
Baltimore, Maryland 21211

Medifacts
44 Eccles Street
Ottawa, Ontario
KIR 6S3

Metropolitan Life Insurance Company
Health & Welfare Division
One Madison Avenue
New York, N.Y. 10010

Modernfold Space Multipliers
Box 310
New Castle, Indiana 47362

M.S. Society
130 Bloor St. W.
Suite 700
Toronto, Ontario. Canada M4W 1B4

Narcotic Education Bureau
1730 Chicago Avenue
Evanston, Illinois 60201

Narcotic Educational Foundation of America
5055 Sunset Boulevard
Los Angeles, California 90027

National Academy of Sciences
National Research Council
Food and Nutrition Board
Washington, D.C. 20025

National Association for Retarded Citizens
2709 Avenue E East
P.O. Box 6109
Arlington, Texas 76011

NCR Corporation
Box 606
Dayton, Ohio 45401

National Clearinghouse for Alcohol Info.
P.O. Box 2345
Rockville, Maryland 20852

National Congress of Parents and Teachers
700 North Rush Street
Chicago, Illinois 60611

National Dairy Council
Program Service Department
111 North Canal Street
Chicago, Illinois 60606

National Easter Seal Society for
Cripple Children and Adults
2023 W. Ogden Avenue
Chicago, Illinois 60612

NEA Order Department
The Academy Building
Saw Mill Road
West Haven, Connecticut 06516

National Education Television
Audiovisual Center
Indiana University
Bloomington, Indiana 47401

National Fire Protection Association
470 Atlantic Avenue
Boston, Massachusetts 02210

National Foundation - March of Dimes
Division of Public Education and
School Relations
800 Second Avenue
New York, N.Y. 10017

Department of Health, Education
and Welfare
Public Health Service
Alcohol, Drug Abuse and Mental
Health Administration
National Institute on Drug Abuse
1400 Rockville Pike
Rockville, Maryland 20852

National League for Nursing, Inc.
10 Columbus Circle
New York, N.Y. 10019

National Multiple Sclerosis Society
205 East 42nd Street
New York, N.Y. 10017

National Research Council
2101 Constitution Avenue
Washington, D.C. 20418

National Rifle Association
1600 Rhode Island Avenue, N.W.
Washington, D.C. 20036

National School Public Relations Assoc.
1801 North Moore Street
Arlington, Virginia 22209

Oral Health Products, Inc.
P.O. Box 45623
Tulsa, Oklahoma 74145

Personal Products
% Association-Sterling Films
600 Grand Avenue
Ridgefield, N.J. 07657

Planned Parenthood-World Population
810 Seventh Avenue
New York, N.Y. 10019

Prevent Blindness
79 Madison Avenue
New York, N.Y. 10016

Prudential Life Insurance Company
Public Relations Department
Prudential Plaza
Newark, New Jersey 07010

Public Affairs Committee
381 Park Avenue South
New York, N.Y. 10016

Public Health Service
Public Inquiries Branch
Washington, D.C. 20025

Publishers Central Bureau
Dept. 439
1 Champion Avenue
Avenel, New Jersey 07131

The Quaker Oats Company
Merchandise Mart Plaza
Chicago, Illinois 60654

Rainbow Bread Company
P.O. Box 268
Denver, Colorado 80201

R.M. Nurseries
P.O. Box 2784
Laguna Hills, California 92653

Ross Laboratories
625 Cleveland Avenue
Columbus, Ohio 43216

Scott Foresman and Company
1900 East Lake Avenue
Glenview, Illinois 60025

Scott Paper Company
Scott Plaza
Philadelphia, PA 19113

Silver Burdett Company
250 James Street
Morristown, New Jersey 10017

SRA Research Associates, Inc.
259 East Erie Street
Chicago, Illinois 60611

SRS Productions, Inc.
4224 Ellenita Avenue
Tarzana, California 91356

Sunshine Learning Aids
P.O. Box 2003
Monterey Park, California 91754

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06115

U.S. Department of Agriculture
Washington, D.C. 20025

U.S. Department of Health, Education
and Welfare
(Children's Bureau, Social Security Adm.
Food and Drug Adm. Office of Education,
Office of Vocational Rehabilitation)
Washington, D.C. 20025

U.S. Department of Health, Education
and Welfare
Public Health Service
Center for Disease Control
Atlanta, Georgia 30333

U.S. Environmental Protection Agency
Washington, D.C. 20460

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20025

Vita Mix Corporation
8615 Usher Road
Cleveland, Ohio 44138

Walt Disney Educational Media Company
500 South Buena Vista Street
Burbank, California 91521

William M. Dennis Film Libraries
2506½ West Seventh Street
Los Angeles, California 90005

World Health Organization
Pan American Sanitary Bureau
Regional Office
1501 New Hampshire Ave. N.W.
Washington, D.C. 20006

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5. Provide teacher inservice. Teacher preparation and interest are at the center of any successful program. Health education focuses on the study of one's physical and mental self--topics which hold innate interest for students. In the hands of an expert teacher health can easily become the most stimulating and rewarding part of a students school experience.

If the health program is to be taught by non-health teachers, an inservice program will need to be developed. Many teachers need the assurance that they are capable of teaching health and that they will enjoy the topic. When possible, principals or other district administrators should be involved in inservices to familiarize them with the materials being presented. Inservice is most popular when it is well-planned, fast-paced, and loaded with teaching suggestions and materials that relate directly to concepts and materials covered in the curriculum guide.

There are numerous resources in Colorado that provide teacher inservice programs in various aspects of health education. A list of these resources is included in this chapter. For additional assistance in setting up teacher inservice programs, contact the Department of Education.

The Rules for the Administration of the Teacher Certification Act of 1975 provide for an endorsement in "health" to be placed on a Colorado Teacher Certificate for those persons who have completed a college's state-approved teacher education program in this area of specialization. The following standard (6.11) indicates the breadth and depth of preparation required for the endorsement. Inquiries concerning approved programs for endorsement in health should be referred to the Teacher Education and Certification Unit of the Colorado Department of Education.

Health Standard for Endorsement:

6.11 HEALTH: To be endorsed in Health, an applicant shall have completed the Approved Program in Professional Education as prescribed in Section 2260-R-4.0 and an approved program in health designed to develop knowledge and skills in the following areas:

6.11 (1) Understanding of man's ecology and interaction with society, with studies in such fields as the biological and behaviorial sciences.

6.11 (2) Understanding of health issues and health problems of the individual in society, such as: emotional and social health, alcohol, tobacco and other drugs, nutrition, and communicable and noncommunicable diseases.

6.11 (3) Physical and psychological human growth and development and their relationship to the health instruction program including family life education and appraisal of health status of the individual

6.11 (4) Evaluation of the validity and reliability of health information and resources.

6.11(4)(a) Consumer health including intelligent selection of health products and health services, consumer protection agencies, health misconceptions and superstitions, health insurance plans and delivery systems.

6.11(4)(b) The identification of emerging health problems and issues.

6.11 (5) Understanding of public health principles and the individual's responsibility in motivating and maintaining public health agencies and organizations, health careers, urban health problems, and disease prevention and control.

6.11 (6) An understanding of the dynamics of accidents and the conditons conducive to safe living.

6.11 (7) Organization and administration of school health programs.

Colorado school districts are encouraged to employ teachers of health who are properly endorsed when and if available. However, they may employ non-endorsed teachers provided that the teacher holds a valid Colorado Teacher Certificate and meets the established accreditation requirements for the subject to be taught.

School districts accredited by the State of Colorado shall meet the requirements published by the Accreditation and Accountability Services Unit of the Colorado Department of Education. Teachers employed by Colorado school districts which are accredited by the North Central Association of Colleges and Schools will be governed by that agency's established standards. It is the responsibility of the employing school district to assign teachers to positions appropriate to their preparation, training and experience.

The University of Northern Colorado at Greeley offers an accredited program in health education through the Division of Health and Safety Education.

6. Pilot the Program. A pilot site for the program should be carefully chosen to allow an unbiased test of the program. Teachers and administrators will need to be thoroughly inserviced as to philosophy, goals, and proposed methodology of the programs. Evaluation procedures must be fully developed and agreed upon. Teacher resource packets and classroom materials must all be in place to get the program off to an even start. Frequent meetings of the staff assigned to the pilot program should be held to discuss any problems that arise over content, materials or methodology. The school principal should be actively involved in this process as he can be a good source of input and can provide solutions to problem situations which may arise.

   A review of the pilot program should provide answers to some of the following programs:

   - Is the program effective--Can the program objectives be reached through the proposed educational activities, or are there other activities that would be more effective--did the kids learn, did they enjoy the activities?

   - Is the program efficient--or can the same objectives be reached with less expenditure of time, effort and money?

   - Is the inservice program adequate--or does it need to be modified, amplified?

   - Were the materials adequate--were they accessible, appropriate to grade-level, etc.?

   - Is the program ready to be recommended and replicated in other schools in the district?

   When the necessary piloting is completed the persons involved should carefully evaluate the results, and present the findings to the administration and the School Board.

7. Develop a Master Plan. A good pilot of the program will not automatically assure implementation of the program throughout the district. A good deal of care must be used to design a Master Plan which takes into account many factors such as the sequence of events necessary, the cost, the time, and the personnel required, the inservice and community involvement. A long term plan may be best to phase in the program thereby spreading the cost and the work of implementing the program over a several year period.

8. Review and Revise Program. To avoid having a static program, regular review and revision should be systematically planned and shared with a continued Health Council. As the program becomes more established meetings may be less frequent and the committee may wish to turn attention to other portions of school health such as services and environment as well as health education.

Once established the health program should be accepted as another academic responsibility and should come before the School Board for consideration in regular rotation with other subject areas.

CHAPTER XIV

SUGGESTED READINGS

Related to Chapter XI

(1) Russell, Robert, Health Education, National Education Association, Washington, D.C., 1975.

A Report from the Joint Committee on Health Problems in Education of the National Education Association, and the American Medical Association. It presents current health problems, some philosophies and modern approaches to health education

(2) Health - United States 1975, Health Resources Administration, Department of Health Education and Welfare, 1976.

Statistical analysis of health care in the United States including information on major health problems, health costs, and health manpower.

(3) Colorado Vital Statistics 1975, Colorado Department of Health, Denver, Colorado, 1977.

A compilation of vital statistics data for the state of Colorado, including major causes of death.

Related to Chapter XII

(1) Byler, Lewis, Totman, Teach Us What We Want To Know, Mental Health Materials Center, Inc., New York, New York 10016, 1969.

Report of a survey on health interests, concerns, and problems of 5[illegible]00 students in selected schools from kindergarten through grade twelve.

(2) Dalis, Eisen, Gothold, Strategies for Coordination, MacMillan Education Services, Inc., Beverly Hills, California, 1971.

A program development guideline for health education.

(3) School Health Education Study, 3M Education Press, St. Paul, Minnesota, 1968.

A national curriculum design project conducted in 1967. Provides conceptual framework for health education, grades K-12.

(4) Contact the Department of Education for samples of other curriculum guides developed in other states or in districts in Colorado.

Related to Chapter XIII

(1) Barrett, Morris, Health Education Guide, Lea and Febiger, Philadelphia, 1974.

A compendium of curriculum concepts and suggested teaching activities in all areas of health education, grades K-12.

(2) School Health Education Study, 3M Education Press, St. Paul, Minnesota, 1968.

A national curriculum design project conducted in 1967. Provides conceptual framework for health education, grades K-12.

(3) Health Instruction: Suggestions for Teachers, American School Health Association, Kent, Ohio, 1977.

A listing of concepts and activities to be incorporated into the curriculum.

(4) Wilgoose, Carl E., Health Education in the Elementary School, W.B. Saunders Company, Philadelphia, 1974.

A guide to planning and implementing a health curriculum, with specific information on concepts, activities, and resources in health education.

(5) Professional Preparation in Dance, Physical Education, Recreation Education, Safety Education and School Health Education, American Association for Health, Physical Education, and Recreation Publications, Washington, D.C., 1974.

The book contains nationally recognized recommendations on teacher preparation and certification.

(6) Educators Guide to Free HPER Materials, HPER, Health, Education, and Recreation, Education Progress Service, Inc., Randolph, Wisconsin 53956, 1977.

A resource guide to health education materials available nationwide.

(9) Information on additional resources can be obtained by contacting the Department of Education or the agencies listed in the resource section.

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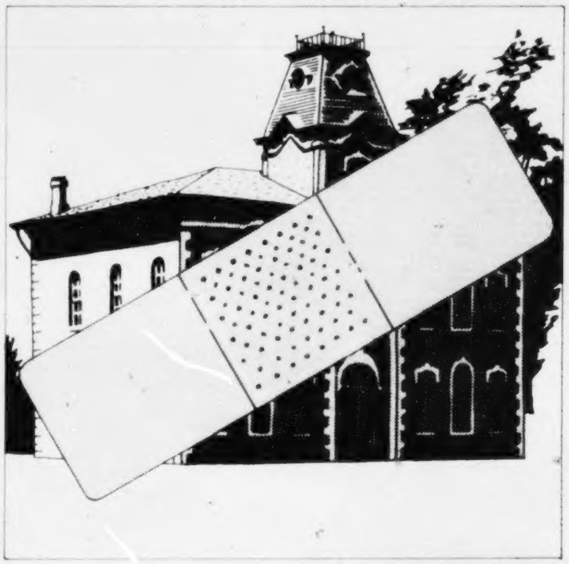

HEALTHFUL SCHOOL ENVIRONMENT

CHAPTER XV

HEALTHFUL SCHOOL ENVIRONMENT

Since children in Colorado are required to spend many years of their childhood in schools, there is an obligation and a responsibility to provide every student with a safe and healthful school environment This healthful school environment should include both the physical and emotional environment. The health of teaching and nonteaching personnel also has an influence upon the students and the school environment.

The emotional environment of schools has become a more recent concern to administrators, teachers, nurses, and parents. Teacher-pupil and pupil-pupil relationships should foster good mental and emotional health attitudes and behavior. The teacher's health status, teaching techniques, and emotional attitudes set the climate in the classroom. These contribute to sound learning. Perhaps one of the most important contributions a teacher or nurse can make is to be alert: alert to each child's personality, his assets and liabilities, his problems and needs. Also, the teacher and nurse should always bear in mind that the "average" child seldom exists, that each child is a fascinating array of variations.

The Standards and Regulations for Schools were passed by the Colorado Board of Health in January 1977. These Standards are for the schools' physical environment, and are the first Colorado has had. These Standards are printed on the following pages. There is also a tool to use with these Standards in evaluating a school building.

The school nurse's role is to observe and report those conditions in the school environment that create health and/or safety hazards and do not comply with the Standards. This report should be made to the school official who is responsible for seeing that the condition is corrected.

It is the responsibility of the local county health agencies and organized health departments to enforce these Standards. If further enforcement is required, the Colorado Department of Health will support the recommendations of these agencies.

COLORADO DEPARTMENT OF HEALTH
4210 East 11th Avenue
Denver, Colorado 80220

STANDARDS AND REGULATIONS FOR SCHOOLS

1.0 ADMINISTRATION

1.1 Authority: Sections 25-1-107 (1) (m), 25-1-108 (1) (c) (I), and 25-5-508; Colorado Revised Status 1973.

1.2 Adopted: January 19, 1977.

1.3 Effective Date: March 22, 1977.

1.4 Purpose: The purpose of these "Standards and Regulations" is to provide minimum sanitation, maintenance, operation, occupancy, and use requirements to safeguard the health of the school occupants and the general public. However, nothing contained in these "Standards and Regulations" shall apply to employees of schools or school districts.

1.5 Application: These "Standards and Regulations" shall apply to all schools.

a. Where the school can prove to the satisfaction of the department that literal enforcement would be unreasonable, and provided the health of the students and other users of the facilities is not endangered, the department shall permit an abatement schedule to provide for a reasonable period for compliance, or an alternate means of compliance to insure an acceptable level of conformance. These regulations shall not limit the powers and duties of local governments to issue such orders and adopt such rules and regulations as stringent as or more stringent than the provisions contained herein; as may be necessary for the local public health and safety.

2.0 DEFINITIONS

2.1 Classroom - Any room used for instructional purposes.

2.2 Department - The Colorado Department of Public Health.

2.3 Refuse - All combustible or noncombustible, putrescible, or nonputrescible wastes.

2.4 Sanitary Facilities - Toilets, urinals, lavatories, showers, utility sinks, and the service rooms provided for installation and use of these units except lavatories, utility sinks, or drinking fountains located in and used in connection with classroom, laboratories, and vocational education shop activities.

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2.5 Sanitation - Devising and applying of measures for preserving and promoting public health; removal or neutralization of elements injurious to health; practical application of sanitary science.

2.6 School - Any facility (public, proprietary, parochial, denominanational, or eleemosynary) which is maintained for educational purposes for six or more persons except: a. Structures or facilities used by a religious, fraternal, political or social organization exclusively for worship, religious instructional or entertainment purposes pertaining to the organization, b. Educational facilities in health facilities licensed by the Colorado Revised Statutes 1973, c. Child care centers licensed by the Colorado Department of Social Services under provisions of Sections 26-6-102 (1) (a) (b) (4) and 26-6-104, Colorado Revised Statutes 1973.

2.7 School Plant - A fixed location that includes the grounds and the academic, administration, and support structures and facilities.

3.0 GROUNDS

3.1 The ground shall be well drained and free from depressions in which water may stand and be allowed to stagnate. The grounds shall be kept free from refuse, weed overgrowth, and other hazards.

3.2 Playground equipment which is installed, or maintained in such a manner as to create a mechanical hazard as defined in CRS 1973, 25-5-502 (14) shall be removed or brought into compliance.

3.3 Entrance walks, building entrances and other such areas shall be illuminated at night when such areas are in use.

3.4 Livestock or poultry on school controlled property shall be located more than fifty (50) feet from food service areas, offices, or classrooms not associated with animal husbandry activities.

3.5 Service roads, parking areas, and walkways shall be maintained to facilitate movement of vehicular and pedestrian traffic and to avoid personal injury.

3.6 Where bicycles are brought to school, a designated area shall be provided for bicycle parking, and the parking area shall be so located as not to obstruct pedestrian or vehicular traffic or obstruct exits.

3.7 Walks, ramps and steps shall be maintained to protect users from personal injury. The walkways shall be free from obstructions and hazardous accumulations of snow and ice. Where mud and sand grates and mud scrapers are installed, they shall be maintained so as to avoid injuries.

4.0 WATER SUPPLY

4.1 The water supply system shall be designed, constructed, maintained, and used to provide a safe, potable, adequate water supply meeting the requirements of the department, including Quality of Water Supplied to the Public, the Colorado Technical Plumbing Code, 25-1-114 (1) (h) CRS 1973, and where applicable, the State Board of Examiners of Water, Well, and Pump Installation Contractors.

4.2 When a total water service interruption exceeds a period of two (2) hours, the school shall be closed, unless dismissal of the pupils would be detrimental to their physical well-being, or alternatives for providing potable water are available that meet the standards of the department.

4.3 Faucets on nonpotable water supply systems used for irrigation or like purposes shall be clearly marked as unsafe for drinking.

4.4 Water supply pumps, distribution, storage, and treatment facilities and other appurtenant mechanical equipment shall be protected from unauthorized access.

4.5 Where water is to be supplied by the school's independent water supply system, plans and specifications for such a water system shall be submitted for approval to the department prior to construction.

5.0 SEWAGE DISPOSAL

5.1 Facilities shall be provided and maintained for the disposal or treatment and disposal of sewage.

5.2 Where a public sewer system is available, all sanitary facilities and all building sewers shall be connected thereto. (Pursuant to 32-4-113 (1) (m) CRS 1973). If a public sewer system is not available, a sewage disposal system meeting the requirements of the department shall be installed, and all plumbing fixtures and building sewers shall be connected thereto. (Pursuant to 25-8-704 (1) CRS 1973).

5.3 Where a total sewer service interruption exceeds a period of two (2) hours, the school shall be closed unless dismissal of the pupils would be detrimental to their physical well-being, or alternatives for providing adequate sanitary facilities are available.

5.4 Where nonwater carriage sanitary facilities are permitted, they shall be provided and installed in accordance with requirements of the department.

5.5 In all new schools and schools modifying existing sewage disposal systems, plans shall be submitted to the department for review and approval in accordance with provisions of 25-8-704, CRS 1973, prior to construction.

6.0 REFUSE DISPOSAL

6.1 The storage, collection, transportation and disposal of refuse shall be conducted so as to control odors, insects, rodents, accidents, or other nuisance conditions.

6.2 Durable nonabsorbent, cleanable refuse containers shall be provided, kept in a clean condition and readily accessible.

6.3 Exterior refuse storage areas shall be kept in a clean, sanitary condition. Refuse receptacles for exterior storage of garbage or putrescible wastes shall be provided with covers unless emptied not less than three (3) times weekly and there are no nuisance conditions caused by such storage methods.

6.4 Exterior putrescible waste storage areas shall be located not less than twenty-five (25) feet from food service areas and classrooms.

6.5 Refuse shall be removed from the buildings and collected and removed from the premises as often as necessary, but not less than twice weekly when putrescible wastes are stored.

7.0 INSECT AND RODENT CONTROL

7.1 Rodents and insects shall be controlled to maintain the facility free from vermin. Animals used for instructional purposes shall be kept in a sanitary area and in a manner so as to prevent health hazards.

7.2 All pesticides shall be used in accordance with registered label directions and stored in a safe manner accessible only to authorized personnel.

8.0 BUILDING, OCCUPANCY, SPACE AND USE

8.1 The school plant and accessory buildings shall be maintained in good repair and in a clean sanitary condition.

8.2 No projections from the finished ceiling, including beams, lighting fixtures, pipes, crafts, and art work, shall be less than six feet, eight inches (6'-8") vertical distance from finished floor, unless protective measures are taken to minimize hazards from the projections by padding, painting with contrasting colors, or isolating with use of shelves, planters or like barricading devices.

8.3 Space shall be provided for each person in classroom, libraries, shops, laboratories, vocational training rooms, dining rooms, and other related activity rooms or areas to lessen the possibility of health hazards, and disease transmission.

8.4 Every classroom shall have light and ventilation and every service room shall have light and ventilation, where necessary, to prevent health hazards.

8.5 Where necessary, classroom windows shall be equipped with blinds, shades of translucent material, or other effective means to control natural light.

8.6 Windows, when opened, shall not create an undue health hazard.

8.7 Provisions shall be made for the control of flies, mosquitos, and other insects.

8.8 School buildings shall be maintained and used in conformance with applicable provisions of the 1973 edition of the Uniform Building Code or the building code in existence at the time of initial construction or alteration.

9.0 MECHANICAL REQUIREMENTS

9.1 Every school shall be provided with electrical service and artificial lighting shall be provided throughout the school.

9.2 The electrical lighting system shall be capable of providing at least the following average light level intensities: thirty-five (35) foot candles for classrooms, libraries, offices, laboratories and shops; fifty (50) foot candles for drafting, typing, sewing rooms and other rooms of close eye task activities; twenty (20) foot candles for reception rooms, gymnasiums, service rooms, swimming areas and dining areas; ten (10) foot candles for auditoriums, locker rooms and stairways; and five (5) foot candles for corridors, hallways, storage and utility areas. Light level intensities shall be measured at the work surface or thirty (30) inches from the floor.

9.3 Extreme brightness ratios (glare and shadow) shall be minimized by avoiding glossy surfaces, by use of diffused lighting, use of easily cleanable high light reflectance paints or other finishes for ceilings, walls, and floors, use of window shades, routine cleaning and maintenance of electrical fixtures, and/or such other measures necessary to prevent undue glare and to achieve a high level of maintained light effectiveness.

9.4 The electrical system shall be maintained and used in accordance with applicable provisions of the National Electrical Code.

9.5 Ventilation, mechanical or natural, shall be maintained so as to minimize health hazards due to excessive drafts, extreme temperatures, humidity and temperature fluctuations.

9.6 No open flame unvented heaters, kitchen stoves, or hot plates shall be utilized for space heating purposes. Portable electric heaters with exposed elements shall not be used in any student activity area. Electric hot plates, skillets, or similar type cooking appliances shall be used for food preparation only in kitchen, home economics room, or in rooms specifically designated and equipped for such use.

9.7 The heating system provided shall be properly maintained and capable of providing, in all occupied rooms, minimum room temperatures of sixty (60°) F. sixty (60) inches above the floor in shops and gymnasiums and sixty-five (65°) F. thirty (30) inches above the floor in elementary, secondary, and higher educational school classrooms, and at floor level in kindergartens and day care center areas.

10.0 TOILET, LAVATORY AND BATHING FACILITIES

10.1 Toilet, lavatory, bathing facilities, utility sinks and drinking fountains shall be installed in accordance with provisions of the Colorado Technical Plumbing Code, and shall be designed or maintained as to be readily accessible and usable by the age group being served.

10.2 Where there is exposure to skin contamination with poisonous, infectious or irritating materials, a washing facility shall be available.

10.3 Drinking fountains shall be conveniently located and easily accessible to all school program activities and shall not be installed on sinks in science or art areas, lavatories or sinks in toilet rooms. Use of common drinking cups or vessels is prohibited.

10.4 Hot and cold water under normal operating pressures shall be available for bathing and washing purposes, except that tempered water at ninety to one hundred ten degrees Fahrenheit (90-110° F.) may be delivered to showers and lavatories to conserve heat and heating equipment. Centralized temperatures shall be controlled by the school staff, except where the faucet is so designed that the cold water service is activated first or the system is designed or controlled to prevent discharge of water in excess of one hundred ten degrees (110°) F. through the outlet.

10.5 Functional water outlets shall be available, where necessary, at designated refuse storage areas and at high density student common use areas within fifty (50) feet of the building where heavy accumulations of refuse are generated to minimize hazards and to maintain such areas in a clean, safe condition.

10.6 Plumbing fixtures shall be maintained in working order and in a clean and sanitary manner.

10.7 Connected hoses shall be provided with vacuum breakers or disconnected when not in use.

10.8 Student toilet rooms shall be conveniently located at a travel distance of not more than two hundred (200) feet from any room to be served.

10.9 Floors, walls, and ceilings of all toilet, shower, and locker rooms shall be smooth, easily cleanable, nonabsorbent and shall be maintained in good repair and in a clean, sanitary condition.

10.10 In new construction, a floor drain and a keyed hose bib with a vacuum breaker shall be available for all toilet rooms having a toilet combination of two (2) or more water closets or urinals. The floors in these rooms shall slope to the floor drains.

10.11 Toilet bowls shall be types equipped with nonabsorbent, sanitary toilet seats, and toilet paper shall be available.

10.12 A minimum of nine (9) square feet of floor area shall be provided per shower head in existing structures. New structures shall have twelve (12) square feet of floor area per shower head. Showers shall be constructed to prevent water flow into the drying or dressing room space. Shower floors shall have a nonskid surface.

10.13 Soap and single service towels shall be available for all lavatory facilities, except that mechanical warm air dryers may be used in lieu of towels.

10.14 Swimming pools shall be constructed, operated, and maintained in accordance with Colorado Department of Health Regulations and Standards Governing Swimming Pools.

10.15 Plans and specifications for the installation of sanitary facilities in existing schools being remodeled to increase the occupant load shall be submitted for review and approval in accordance with departmental regulations prior to construction.

11.0 EQUIPMENT AND SUPPLIES

11.1 Instructional, athletic, or recreational equipment shall be maintained in a clean, safe condition.

11.2 Gym equipment shall be kept clean and in good repair. Body contact equipment surfaces shall be routinely cleaned and sanitized to minimize the potential for disease transmission.

11.3 Facilities shall be available for the proper storage of clothing and of athletic, instructional, and recreational equipment and supplies to minimize health hazards and to facilitate cleaning.

11.4 Cleaning materials, tools, and maintenance equipment shall be provided and shall be safely stored.

11.5 Toxic or hazardous materials shall be stored separately in a ventilated, locked, fire-resistant area.

11.6 Kindergartens, health service rooms, or any other areas, where sleeping is specifically permitted shall be provided with sleeping facilities including cots or pads, with washable or disposable covers, that are maintained in good repair and provided in a clean condition for each new user.

11.7 Towels and wash cloths, and other linens, where provided shall be laundered in such a manner to insure exposure to a water temperature of one hundred-sixty-eight degrees (168°) F. for combined wash and rinse period of at least twenty-five (25) minutes or an equally effective washing procedure. Such linens, towels, and wash cloths, where provided, shall be furnished clean at reasonable time intervals.

12.0 SCHOOL OPERATED FOOD SERVICE

12.1 Food served by the school but not prepared on site shall be obtained from sources inspected and approved by the department. The food shall be transported, stored and served in a manner so as to prevent contamination or adulteration.

12.2 Dining activities shall be confined to rooms or areas designated by the school administrator. The dining area shall be clean, and sanitary.

12.3 Each school preparing or serving food shall obtain a certificate of inspection as required by provisions of Section 12-44-211 (a), CRS 1973.

12.4 Food service activities shall be conducted in conformance with the physical and operational requirements of the Rules and Regulations Governing the Maintenance of Food Service Establishments in the State of Colorado.

12.5 Plans and specifications for construction or alteration of food service facilities shall be submitted in accordance with requirements of Section 12-44-206 (2), CRS 1973.

13.0 LABORATORY, INDUSTRIAL, AND VOCATIONAL HAZARDS

13.1 Provisions shall be made for protection of students engaging in industrial arts, physical sciences, or vocational educational activities using hazardous devices and articles of equipment including the development and posting of operating instructions, regulations, and procedures.

13.2 Chemicals, poisons, corrosive substances and flammable liquids shall be labeled, proper use and storage controls exercised, and a list of poison antidotes posted. The telephone number and location of the nearest poison control center shall be prominently posted near the telephone.

13.3 Exposure to noise or toxic dusts, gases, mists, fumes or vapors shall be controlled to avoid health hazards.

13.4 Use of X-ray machines and other electronic devices producing ionizing or nonionizing radiation, radioactive materials, shop or laboratory chemicals and equipment shall conform to Colorado Department of Health Regulations Pertaining to Occupational Health and Radiation Control and to requirements of the Colorado Occupational Safety and Health Regulations.

14.0 HEALTH SERVICE

14.1 Basic first aid equipment and medical supplies conforming to the current edition of an American Red Cross Standard First Aid Book, or equivalent, and such antidotes as recommended by the Colorado Poison Control Center, shall be provided and kept conveniently available for emergency use.

14.2 At least one staff member shall be on duty, at all times during the school day and school sponsored use periods, who has a current certification for the American Red Cross Standard First Aid Course or an equivalent.

14.3 Separate rooms or areas shall be available in every school plant for emergency use in providing care for persons who are ill, infested with vermin, or suspected of having contagious diseases.

14.4 Every emergency care room or area shall be provided with at least one cot for each four hundred (400) students or a fractional part thereof, and each cot shall have a washable surface, or cover, or be provided with disposable sheets and pillow cases for each user.

14.5 Prescription medications shall be present in a school only on an individual prescription basis and shall be administered only as prescribed and on a physician's written authorization. An individual record shall be kept of such prescription medications administered by school personnel.

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14.6 Prescription medications, as described in Section 14.5, administered by the school shall be stored in a secure, locked, clean container or cabinet.

14.7 Telephone or radio communications shall be provided and kept available for emergency purposes.

14.8 A plan with common procedures for handling emergency medical services and a current list of emergency services with telephone numbers shall be posted in a prominent place.

15.0 MISCELLANEOUS

15.1 Procedures shall be established, as may be indicated, at each school district to provide for the protection of the health of the students and other users. Operational and maintenance programs shall be scheduled and conducted to keep the school in a clean, sanitary condition.

15.2 School buses shall be maintained to avoid health hazards.

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Evaluation sheet to be used for the Standards and Regulations for Schools which were approved by the Colorado Board of Health in January, 1977.

HEALTHFUL SCHOOL ENVIRONMENT

School Building Evaluated:____________________ School District:_________

Area Evaluated	In Compliance	Non Compliance	Date Noncompliance Was Reported to School Officials		Not Evaluated
			Reported	Corrected	
Grounds					
Section 3.1					
Section 3.2					
Section 3.3					
Section 3.4					
Section 3.5					
Section 3.6					
Section 3.7					
Water Supply					
Section 4.1					
Section 4.2					
Section 4.3					
Section 4.4					
Section 4.5					
Sewage Disposal					
Section 5.1					
Section 5.2					
Section 5.3					
Section 5.4					
Section 5.5					
Refuse Disposal					
Section 6.1					
Section 6.2					
Section 6.3					
Section 6.4					
Section 6.5					
Insect and Rodent Control					
Section 8.1					
Section 8.2					
Section 8.3					
Section 8.4					
Section 8.5					
Section 8.6					
Section 8.7					
Section 8.8					
Mechanical Requirements					
Section 9.1					
Section 9.2					
Section 9.3					
Section 9.4					
Section 9.5					
Section 9.6					
Section 9.7					

Area Evaluated	In Compliance	Non Compliance	Date Noncompliance Was Reported to School Officials		Not Evaluated
			Reported	Corrected	
Toilet, Lavatory, Bathing Facilities					
Section 10.1					
Section 10.2					
Section 10.3					
Section 10.4					
Section 10.5					
Section 10.6					
Section 10.7					
Section 10.8					
Section 10.9					
Section 10.10					
Section 10.11					
Section 10.12					
Section 10.13					
Section 10.14					
Section 10.15					
Equipment and Supplies					
Section 11.1					
Section 11.2					
Section 11.3					
Section 11.4					
Section 11.5					
Section 11.6					
Section 11.7					
School-Operated Food Service					
Section 12.1					
Section 12.2					
Section 12.3					
Section 12.4					
Laboratory, Industrial, and Vocational Hazards					
Section 13.1					
Section 13.2					
Section 13.3					
Section 13.4					
Health Service					
Section 14.1					
Section 14.2					
Section 14.3					
Section 14.4					
Section 14.5					
Section 14.6					
Section 14.7					
Section 14.8					
Miscellaneous					
Section 15.1					
Section 15.2					

Reasons for checking "Not Evaluated" column (give section number when giving reason).

Recommended steps to be taken:

Evaluation was done ____________ by ______________________________
date name and title

Evaluation was presented to ______________________________
name and title

on ____________.
date

COLORADO DEPARTMENT OF HEALTH
SCHOOL SURVEY REPORT

Category __________
Account No. _______

School ______________________________ County ______________ District ________________
Address ____________________________________ Principal ______________________________

☐ Elementary
☐ Junior High
☐ Senior High
☐ Other ______________________

Enrollment __________
Food Service ☐
Swimming Pool ☐

Public Water ☐
Private Water ☐
Public Sewage ☐
Private Sewage ☐

Survey of the above facility revealed the following deficiencies:

3.0 GROUNDS
- ___ Location - space
- ___ Grounds - drainage, hazards
- ___ Walks - drives - parking
- ___ Playground equipment

4.0 WATER
- ___ Safe - bacteriological - chemical
- ___ Adequate - pressure - volume

5.0 SEWAGE DISPOSAL
- ___ Facilities - maintenance

6.0 REFUSE DISPOSAL
- ___ Collection - storage - disposal

7.0 VECTOR CONTROL
- ___ Insects - rodents - vermin proof

8.0 BUILDING
- ___ Structure - maintenance - clean - exits
- ___ Space - use - ventilation
- ___ Other

9.0 MECHANICAL
- ___ Lighting - glare - brightness
- ___ Heating - temperature - humidity
- ___ Electrical

10.0 TOILET - LAVATORY - BATHING
- ___ Plumbing per code
- ___ Fixtures - number - location
- ___ Floors - walls - ceiling
- ___ Maintenance - clean
- ___ Drinking fountains

TOILET - LAVATORY - BATHING
- ___ Hot and cold water
- ___ Water fountains - outside outlets
- ___ Shower - dressing space
- ___ Soap - towels - dryers - receptacles

11.0 EQUIPMENT - SUPPLIES
- ___ Adequate - repair - clean
- ___ Cleaning materials
- ___ Storage of supplies, etc.
- ___ Sleeping facilities
- ___ Laundry - process - storage

12.0 FOOD SERVICE (Use San: F5) but check here
- ___ Protection - posted instructions
- ___ Toxics labeled - stored
- ___ Poison control phone number
- ___ Noise - gas - dust exposure
- ___ Emergency washing unit

14.0 HEALTH SERVICES
- ___ First aid equipment - supplies
- ___ One staff certified R-C
- ___ Separate emergency area
- ___ Emergency room cots
- ___ Medication - handling - dispensing
- ___ Emergency services - posted phone

15.0 MISCELLANEOUS
- ___ Operation - maintenance - procedures
- ___ School buses clean
- ___ Swimming pool
- ___ Other

(✓) Unsatisfactory - Explain in this remarks section:

Date ______________ Time ____________ Environmentalist ______________________________
Reviewed with _________________ Title ______________ Copy to Colo. Dept. of Health and
____